

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                     |  |   |   |   |  |  |  |  |
|--|--|-------------------------------------|--|---|---|---|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                     |  |   |   |   |  |  |  |  |
| 2601 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02580   |  |                                     |  |   |   |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>   |  |                                     |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>D. C.</b> b. COUNTY <b>✓</b>   |   |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Laurel</b>  |  |                                     |  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>   |   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Children's Center</b>   |  |                                     |  |   | d. STREET ADDRESS<br><b>1427 Montello Avenue, N.E.</b>  |   |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Conrad</b> Middle <b>Arnold</b> Last <b>Anderson</b>   |  |                                     |  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>24</b> Year <b>1961</b>   |   |  |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>C</b>        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>12-27-43</b>   |  | 9. AGE (In years last birthday) <b>17</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>  |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>D.C.</b>                    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |
| 13. FATHER'S NAME<br><b>Joseph Anderson</b>  |  |                                     |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Connie Bristow</b>   |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>  |  |                                     |  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address<br><b>Children's Center File, Laurel, Maryland</b> |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Third Degree Burns</b><br>DUE TO (b) <b>Epilepsy</b><br>DUE TO (c) <b>917.7</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>20e. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Exposure to live steam (he broke the heating pipe)</b><br>20c. TIME OF INJURY Month, Day, Year<br><b>5:20</b> Hour <b>3-24-61</b> p.m.<br>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Institution</b><br>20f. (City or town) (County) (State)<br><b>Laurel, Anne Arundel, Maryland</b> |  |                                     |  |   |   |   |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>All life</b>   |  |                                     |  |   |   |   |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                     |  |   |   |   |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                                     |  |   |   |   |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Gustave H. Faubert, M.D.</b>  |  |                                     |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) <b>Glen Burnie, Maryland</b> |   |  |  |  |  |
| EXAMINER'S NAME (Type)<br><b>Gustave H. Faubert, M.D.</b>  |  |                                     |  |   | DATE SIGNED<br><b>3/24/61</b>   |   |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>3/29/61</b> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Carver Park</b>  |   | 22d. LOCATION (City, town, or country) (State)<br><b>Laurel Md.</b>         |  |  |  |  |
| 23. FUNERAL DIRECTOR<br><b>By Willie E. Asmwood</b>  |  |                                     |  |   | ADDRESS<br><b>4609-14th</b>   |   | 24a. REC'D BY REGISTRAR<br><b>MAR 28 '61</b> |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b> |  |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02581**

2602

|  |                                  |   |  |  |                                |   |  |
|--|----------------------------------|---|--|--|--------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>                      |                                |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>none</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Davidsonville</u>   |                                | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Anne Arundel General Hospital DOA</u>   |                                  |   |  | d. STREET ADDRESS<br><u>none</u>   |                                |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>HARRY</u> Middle <u>ARMIGER</u> Last   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>14</u> Year <u>1961</u>  |                                |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 27, 1894</u> | 9. AGE (in years last birthday)<br><u>66</u> yrs.  | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Foreman</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>County Road Dept.</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>A.A. County, Maryland</u>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>James Armiger</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Martha Lowe</u>   |                                |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>Yes <input type="checkbox"/> No <input type="checkbox"/> WW I <input checked="" type="checkbox"/>  |                                  | 16. SOCIAL SECURITY NO.<br><u>R16-42-6888</u>   |  | 17. INFORMANT<br><u>Mrs. Annie Asquith Armiger- Wife- same as # 2</u>  |                                |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Cadher</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u><br>DUE TO (c)   |                                  |   |  |  |                                | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |  |                                |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |                                |   |  |
| 20c. TIME OF INJURY<br>Hour o. m. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                  |   |  |  |                                |   |  |
| ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>  |                                  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                |   |  |
| EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>  |                                  |   |  | DATE SIGNED <u>3/14/61</u>   |                                |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>March 18, 1961</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Davidsonville Methodist Cemetery</u>  |                                | 22d. LOCATION (City, town, or county) (State)<br><u>Davidsonville, Md.</u>                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>HOPPING FUNERAL HOME</u>  |                                  |   |  | ADDRESS<br><u>Annapolis, Maryland</u>  |                                | 24a. REC'D BY REGISTRAR<br><u>MAR 20 '61</u>  |  |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>   |                                |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                  |   |   |  |   |                                      |   |  |   |  |
|--|--|----------------------------------|---|---|--|---|--------------------------------------|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |  |   |                                      |   |  |   |  |
| CERTIFICATE OF DEATH   |  |                                  |   |   |  |   |                                      |   |  |   |  |
| 2603   |  |                                  |   |   |  |   |                                      |   |  |   |  |
| 02582  |  |                                  |   |   |  |   |                                      |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |                                  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>b. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |                                      |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |                                  |   |   |  | c. LENGTH OF STAY IN 1b<br><b>10</b> <b>Annapolis</b>   |                                      |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Dead on Arrival</b><br><b>Anne Arundel General Hospital</b>   |  |                                  |   |   |  | d. STREET ADDRESS<br><b>20 Woodlawn Ave.,</b>   |                                      |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Eliza J BASSFORD</b>   |  |                                  |   |   |  | 4. DATE OF DEATH<br><b>March 28 19 61</b>   |                                      |   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 7, 1885</b>  |                                      | 9. AGE (In years last birthday)<br><b>76</b> yrs.                     |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own Home</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                           |  |   |  |
| 13. FATHER'S NAME<br><b>George Aisquith</b>  |  |                                  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ireland</b>   |                                      |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |                                  |   |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |                                      |   |  |   |  |
| 17. INFORMANT<br><b>Mr James A. Bassford- Son- Same as # 2</b>   |  |                                  |   |   |  | Address   |                                      |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute dilatation of the heart (Myocardium)</b><br><b>434.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO<br>(e), stating the underlying cause last. |  |                                  |   |   |  |   |                                      |   |  | INTERVAL BETWEEN ONSET AND DEATH              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                  |   |   |  |   |                                      |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |   |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State) |   |  |   |  |
| 21. I certify that (I) <del>(not present)</del> attended the deceased from <b>June 28, 19 59</b> to <b>Mar. 28, 19 61</b> , that (I) <del>(not)</del> last saw the deceased alive on <b>Mar. 28, 19 61</b> , and that death occurred at <b>10:10 P.M.</b> from the causes and on the date stated above.                          |  |                                  |   |   |  |   |                                      |   |  |   |  |
| 22a. SIGNATURE<br><b>Albert L. Anderson</b>  |  |                                  |   |   |  | 22b. DATE SIGNED<br><b>3/29/61</b>  |                                      |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Albert L. Anderson</b>  |  |                                  |   |   |  | 22d. ADDRESS<br><b>44 Southgate Ave., Annapolis, Md.</b>  |                                      |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  | 23b. DATE THEREOF<br><b>March 31, 1961</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Bluff Cemetery</b>      |   |                                      | 23d. LOCATION (City, town or county) (State)<br><b>Annapolis, Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>  |  |                                  |   |   |  | 25a. REC'D BY REGISTRAR<br><b>APR 3 '61</b>   |                                      |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |                                  |   |   |  |   |                                      |   |  |   |  |

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page

VS A15 (4)  
15M 9/55

AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within  
stained by the hospital or attending physician.  
AL DIRECTOR: After this certificate has been signed by the attending physician and completely fill  
could be detached for use as the burial-transit permit. Then please remove carbon papers. Page

after death: Page 4

by the funeral director  
4 2 should be filed with

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G283 3/20/61 mh

2604

CERTIFICATE OF DEATH

Reg. Dist. No.

02583

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis, Maryland</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>15 Days</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>USNH, Annapolis, Maryland</u>  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis, Maryland</u>  |  |   |  |
| f. STREET ADDRESS<br><u>114 Duke Of Gloucester Street</u>   |  |   |  | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Elizabeth Rea Benson</u>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>March 11 1961</u>  |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>Cauc</u>               |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>11-29-89</u>   |  |
| 9. AGE (In years last birthday)<br><u>71</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  | 11. BIRTHPLACE (State or foreign country)<br><u>California</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House Wife</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>_____  |  |   |  |
| 13. FATHER'S NAME<br><u>Alex Thompson</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Moore Mary Bernard</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br>_____  |  | 17. INFORMANT<br><u>Howard H J Benson</u> Address <u>(2)</u>                                      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Rheumatic valvulitis, inactive with deformity of the Aortic Valve.</u><br>252.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease inactive, Aortic Insufficiency 10 yrs</u><br>DUE TO (c) <u>Hyperthyroidism without evident goiter.</u><br>-- -- |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
|   |  |   |  | 20f. (City or town) (County) (State)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that I attended the deceased from <u>24 Feb 61, 1961</u> to <u>11 MAR 1961</u> , that I last saw the deceased alive on <u>10 MAR 1961</u> , and that death occurred at <u>1210 A M</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>US. NAVAL HOSPITAL, ANNA. MD.</u> DATE SIGNED <u>11 MAR 61</u>   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <u>R.G. Williams Jr.</u>   |  |   |  | M.D. _____  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>R.G. Williams Jr. CDR MC USN</u>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAC (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>3-14-1961</u>         |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Arlington V</u>                               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>MAR 14 '61</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hume</u>   |  |

MEDICAL CERTIFICATION

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2025

3880

2605

## CERTIFICATE OF DEATH

Reg. Dist. No. 02584

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>BALTO H.H.Co.</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>903 WANDA Rd. Linthicum</b>  |  | e. STREET ADDRESS <b>903 Wanda Rd. 1</b>   |  |
| 3. NAME OF DECEASED (Type or print) <b>MARY First ANNA Middle BIRSNER Last</b>   |  | 4. DATE OF DEATH Month <b>Mar</b> Day <b>8</b> Year <b>1961</b>  |  |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>July 13 1893</b>             |
| 9. AGE (In years last birthday) <b>67</b> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>William Jendraszkewicz</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Agnes Rutkowski</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>213056893</b>   |  |
| 17. INFORMANT <b>Herman H. Birsner</b>   |  | Address <b>903 Wanda Rd</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>72200</b> DUE TO (b) <b>Rheumatoid arthritis, general</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>12 years</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)             |
| 21. I certify that I attended the deceased from <b>Oct 57</b> , to <b>Mar 8</b> , 1961, that I last saw the deceased alive on <b>Mar 7</b> , 1961, and that death occurred at <b>7:10 A.M.</b> from the causes and on the date stated above.   |  |  |  |
| ACTUAL SIGNATURE <b>Joseph Taler</b>   |  | ADDRESS (Street, city or town, state) <b>102 Bd A Blvd. N.E.</b>   |  |
| PHYSICIAN'S NAME (Type) <b>JOSEPH TALER</b>  |  | DATE SIGNED <b>3-8-61</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>March 11-61</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Old Frederick Rd Balto Md</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Bree</b>   |  | ADDRESS <b>1800 E. Lombard St.</b>   |  |
| 24a. REC'D BY REGISTRAR <b>MAR 10 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02585

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b><br>c. LENGTH OF STAY IN 1b<br><b>18</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b><br>d. STREET ADDRESS <b>164 Third St.,</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>BLUNT</b> Last <b>BLUNT</b>  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>6</b> Year <b>1961</b>  |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>Negro</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>August 24, 1907</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oysterman</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>  | 9. AGE (In years last birthday) <b>53</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>  |   |
| 13. FATHER'S NAME <b>Charles Blunt</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Hall</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |   | 16. SOCIAL SECURITY NO. <b>NO</b>   |   |
| 17. INFORMANT <b>Mrs Emma Cook</b>   |   | Address <b>87 Charles St, Annapolis.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Wiemer</b><br>DUE TO <b>592X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Diffuse Glomerulonephritis</b><br>DUE TO <b>Pulmonary Edema</b> (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b><br><b>1 yr.</b>                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (Deceased) attended the deceased from <b>Mar. 3, 1961</b> to <b>Mar. 6, 1961</b> , that (I) (me) last saw the deceased alive on <b>Mar. 6, 1961</b> , and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE <b>Theodore H. Johnson</b> M.D.   |   | 22b. DATE SIGNED <b>3-7-61</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Theodore H. Johnson</b>  |   | 22d. ADDRESS <b>37 Calvert St., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF <b>3-10-61</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Beverly Hill</b>  | 23d. LOCATION (City, town or county) (State) <b>Annapolis, Md</b>                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Theodore H. Johnson</b>  |   | 25a. REC'D BY REGISTRAR <b>MAR 10 '61</b>   |   |
| ADDRESS <b>Annapolis, Md</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2607

CERTIFICATE OF DEATH

02586

Items 7, 8 & 9 Fill in G205 3/27/61 iwr

|   |                               |  |                                       |  |  |   |   |
|---|-------------------------------|--|---------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |                               |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galesville</u>  |                               |  |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galesville, Md.</u>                            |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                               |  |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |  |   |   |
| 3. NAME OF DECEASED (Type or print) First <u>Jan</u> Middle <u>Brzezinski</u> Last <u>Brzezinski</u>  |                               |  |                                       | 4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1961</u>   |  |   |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 11, 1889</u> |  | 9. AGE (In years lost birthday) <u>71</u> yrs. | IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>                                     | IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SOLDIER</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>US ARMY</u>   |                                       | 11. BIRTHPLACE (State or foreign country) <u>Galicin Poland</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   |
| 13. FATHER'S NAME <u>John BRZEZINSKI</u>  |                               |  |                                       | 14. MOTHER'S MAIDEN NAME <u>Rose BRZEZINSKI</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>   |                               | 16. SOCIAL SECURITY NO. <u>none</u>  |                                       | 17. INFORMANT Address <u>AMELIA BRZEZINSKI Galesville Md.</u>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br>420.0 DUE TO <u>Arteriosclerotic heart disease &amp; congestive heart failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> |                               |  |                                       |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> years <u>  </u>                   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |                               |  |                                       |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work   |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> 19 <u>61</u> , to <u>March 13</u> 19 <u>61</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>March 7</u> 19 <u>61</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.   |                               |  |                                       |  |  |   |   |
| 22a. SIGNATURE <u>Willard F. Smith</u>  |                               |  |                                       | 22b. DATE SIGNED <u>3/14/61</u>  |  | 22c. PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>                            |   |
| 22d. ADDRESS <u>Shadyside, Md.</u>  |                               |  |                                       | 22e. ADDRESS <u>  </u>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>3/14/61</u>   |                                       | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>                   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Galesville Md</u>   |                               |  |                                       | 25a. REC'D BY REGISTRAR DATE <u>MAR 17 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>                                    |   |

02550

CERTIFICATE OF DEATH

2007

Goldenville  
Giles, M.

Male White  
Jan 13 1921

2-018

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WILLIAM F. SMITH MD  
JAN 13 1921  
Giles, M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2608  
CERTIFICATE OF DEATH  
02587

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b><br>c. LENGTH OF STAY IN 1b<br><b>3 mos. 28 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Wicomico</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Salisbury</b><br>d. STREET ADDRESS<br><b>618 West Isabella Street</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Sarah L. Burris</b>  |                                  | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>23</b> Year <b>1961</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>July 7, 1909</b>              |
| 9. AGE (In years last birthday)<br><b>51 ?</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>15</b>   | 11. IF UNDER 24 HRS.<br>Hours <b>1</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Irving S. Parsons</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mattie Daniels</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>218 34 7719</b>   |  |
| 17. INFORMANT<br><b>Hospital Records</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Myocardial Infarction</b><br>(c) <b>Hypertensive and Arteriosclerotic Cardiovascular Disease</b><br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>  |                                  | 20f. (City or town) (County) (State)<br><b>-----</b>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11/25</b> , 19 <b>60</b> , to <b>3/23/</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>3/23/</b> , 19 <b>61</b> , and that death occurred at <b>2:00</b> a.m., from the causes and on the date stated above.  |                                  |   |  |
| 22a. SIGNATURE<br><b>Hildegard Heard Reissman</b> M.D.  |                                  | 22b. DATE SIGNED<br><b>3/23/61</b>  |  |
| 22c. PHYSICIAN'S NAME (Typed)<br><b>Hildegard Heard Reissman, M. D.</b>   |                                  | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>3-26-61</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREEN ACRE Cem.</b>  |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Salisbury, Md</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Thornton B. Jolley</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>MAR 29 '61</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>  |                                  |   |  |

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2008

located

being

Anne Arnold

Bellevue

3 mos. 23 days

Greenville

618 East Larchella Street

Greenville State Hospital

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burial

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Sarah

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4/19/08

x

negro

female

U.S.A.

Married

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Unemployed

Mabel S. Nichols

Irving S. Parsons

hospital records

unknown

No

Greenville State Hospital

Greenville State Hospital

Greenville State Hospital

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11/23

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11/23/08

Greenville State Hospital, Maryland

Greenville State Hospital, Maryland

Greenville State Hospital, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2609

## CERTIFICATE OF DEATH

02588

|   |   |  |   |
|---|---|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>               |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Crownsville</u>  |   | c. LENGTH OF STAY IN TB<br><u>10 mos. 20 days</u>  |   |
| c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Tacoma Park</u>  |   | d. STREET ADDRESS<br><u>300 Vine Street</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Crownsville State Hospital</u>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>Thomas</u> First <u>T</u> Middle <u>T</u> Last <u>Byrd</u>   |   | <b>4. DATE OF DEATH</b><br>Month <u>3</u> Day <u>17</u> Year <u>1961</u>   |   |
| <b>5. SEX</b><br><u>Male</u>  | <b>6. COLOR OR RACE</b><br><u>Negro</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>12/3/1901</u> |
| <b>9. AGE</b> (In years last birthday) <u>59 yrs.</u>   |   | <b>10. IF UNDER 1 YEAR</b><br>Months <u>15</u> Days <u>X</u>   |   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Roofer</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Unknown</u>   |   |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Virginia</u>   |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>   |   |
| <b>13. FATHER'S NAME</b><br><u>Thomas Byrd</u>  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Sylvia ?</u>   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |   | <b>16. SOCIAL SECURITY NO.</b><br><u>Unknown</u>   |   |
| <b>17. INFORMANT</b><br><u>Hospital Records</u>   |   | Address  |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the Esophagus</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause last. DUE TO       |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   | <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br>-----   |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br><u>Hour</u> <u>am</u> <u>pm</u> <u>19</u>  |   | <b>20d. INJURY OCCURRED</b><br><u>While</u> <u>Not While</u><br>at work <input type="checkbox"/> at work <input type="checkbox"/>                                  |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br>-----  |   | <b>20f. (City or town)</b> (County) (State)<br>-----   |   |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/27</u> , 19 <u>60</u> , to <u>3/17</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/17/61</u> , 19 <u>61</u> , and that death occurred at <u>4:20</u> , from the causes and on the date stated above. |   |  |   |
| <b>22a. SIGNATURE</b><br><u>Hildegard H. Reissmann, M.D.</u>  |   | <b>22b. DATE SIGNED</b><br><u>3/17/61</u>  |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Hildegard H. Reissmann, M.D.</u>  |   | <b>22d. ADDRESS</b><br><u>Crownsville State Hospital, Maryland</u>   |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |   | <b>23b. DATE THEREOF</b><br><u>3-24-61</u>   |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Harmony</u>   |   | <b>23d. LOCATION</b> (City, town or County) (State)<br><u>md</u>   |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>W. N. Bacon</u>   |   | <b>25a. REC'D BY REGISTRAR</b><br><u>Arthur S. Thomas</u>  |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>1722 7th St. N.W.</u>   |   | <b>DATE</b><br><u>MAR 28 '61</u>   |   |

08282

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director, and page 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2610

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02589

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort George G. Meade</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort George G. Meade</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>United States Army Hospital</b>  |  |  |  | d. STREET ADDRESS<br><b>Quarters # 7639-A</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>PATRICIA</b> Middle <b>JEANNETTE</b> Last <b>BYRNES</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>8</b> Year <b>19 61</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Cau</b>                       |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> N/A <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>1:12 PM</b><br><b>8 March 1961</b>  |  |
| 9. AGE (In years last birthday)<br><b>— yrs.</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>—</b> Days <b>—</b> |  | 11. IF UNDER 24 HRS.<br>Hours <b>1</b> Min. <b>8</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>—</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                      |  |
| 13. FATHER'S NAME<br><b>Robert Byrnes</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Lorraine Cadorette</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>—</b>  |  | 16. SOCIAL SECURITY NO.<br><b>—</b>                  |  | 17. INFORMANT<br><b>Father</b> Address <b>Qtrs 7639-A Ft Geo G. Meade, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Possible brain damage</b><br>DUE TO <b>760.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Frank Breech Delivery</b><br>DUE TO (c) <b>—</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>—</b> |  |  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b> p. m. <b>—</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town) (County) (State)  |  |  |  | 20g. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) <b>(not hospital)</b> attended the deceased from <b>1:12 PM 8 Mar 61</b> to <b>2:20 PM 8 Mar 61</b> that (I) <b>(x)</b> last saw the deceased alive on <b>8 Mar 61</b> 19 <b>—</b> , and that death occurred at <b>2:20 PM</b> from the causes and on the date stated above.   |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br><b>Herman I. Rosenberg, Capt MC</b>   |  |  |  | 22b. DATE SIGNED<br><b>9 Mar 61</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>HERMAN I. ROSENBERG, Capt., M.C.</b>                           |  |
| 22d. ADDRESS<br><b>USA Hosp Ft Geo G. Meade, Md.</b>  |  |  |  | 22e. ADDRESS<br><b>USA Hosp Ft Geo G. Meade, Md.</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>March 11, 1961</b>           |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>North Side Catholic Cem. Allegheny Co. Maryland</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Allegheny Co. Maryland</b>                    |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Elle Witt Donaldson, Laurel, Maryland</b>  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 14 61</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |  |

2050383XV3

05388

CERTIFICATE OF BIRTH

3838

(M)

(J)

*[Faint, mostly illegible text from a birth certificate form, including fields for name, date, and location.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2611

## CERTIFICATE OF DEATH

02590

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>  |  | c. LENGTH OF STAY IN 1b<br><u>4 mos.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |  | d. STREET ADDRESS<br><u>65 East Street.</u>                         |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Honnewood Convalescent Home</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>Ursula Hook CAMPBELL</u>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>March 10 1961</u>   |  |   |  |
| 5. SEX <u>F</u>   |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Month Day Year<br><u>10-12-98</u> 62 yrs.       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>BALTIMORE MD</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                          |  |
| 13. FATHER'S NAME<br><u>JOHN HOOK</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>JOSEPHINE LAUDUS</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO. (If yes, give number or date of service)  |  | 17. INFORMANT<br>Address<br><u>MRS MARCELLA CICCARRONE</u> (2)   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Coccyx</u><br>(a), stating the underlying cause last. (c) <u>Carcinoma Cervix, Stage IV</u> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 mos.</u><br><u>13 mos.</u> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br><u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/25, 1960</u> to <u>3/10, 1961</u> , that (I) (we) last saw the deceased alive on <u>3/2, 1961</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Stuart M. Christhilf</u>   |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Stuart M. Christhilf</u>   |  |   |  | 22d. ADDRESS<br><u>69 Franklin St., Annapolis, Md.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>3-13-1961</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St Marys Cem</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Annapolis Md</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>James M. Taylor Sr</u>   |  |   |  | ADDRESS<br><u>Annapolis Md.</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>MAR 14 '61</u>                   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hurd</u>  |  |   |  |

7250

430

2612

CERTIFICATE OF DEATH

Reg. Dist. No.

02592

|   |                           |  |  |  |  |   |  |
|---|---------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anne Arundel</i> MARYLAND   |                           |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel</i> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater</i>   |                           |  |  | c. LENGTH OF STAY IN 1b <i>60 years</i>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                           |  |  | d. STREET ADDRESS <i>Rt 1, Box 285</i>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <i>Harry</i> First <i>Collison</i> Last   |                           |  |  | 4. DATE OF DEATH <i>March 2, 1961</i> Month <i>March</i> Day <i>2</i> Year <i>1961</i>   |  |   |  |
| 5. SEX <i>M</i>   | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <i>Feb. 22, 1882</i>  |  | 9. AGE (In years last birthday) <i>79</i> yrs.                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <i>Boat &amp; Home</i>   |  | 11. BIRTHPLACE (State or foreign country) <i>Mayo, Md.</i>   |  | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>                            |  |
| 13. FATHER'S NAME <i>William Collison</i>   |                           |  |  | 14. MOTHER'S MAIDEN NAME <i>Unknown</i>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>  |                           | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <i>Karl R. Collison</i>  |  | Address <i>Rt 1 Box 285 Edgewater, Md</i>                             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac failure</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardio-vascular disease</i><br>DUE TO (c)                         |                           |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>10 hours</i><br><i>5 years</i> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <i>19</i>  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                  |  |
| 21. I certify that I attended the deceased from <i>June 20, 1958</i> to <i>March 1, 1961</i> , that I last saw the deceased alive on <i>March 2, 1961</i> , and that death occurred at <i>9:54 A.M.</i> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <i>Rt 1 Box 277-M Edgewater, Md.</i> DATE SIGNED <i>3/2/61</i> |                           |  |  |  |  |   |  |
| ACTUAL SIGNATURE <i>Sylvia M. Linn</i> M.D.   |                           |  |  | PHYSICIAN'S NAME (Type) <i>Sylvia M. Linn</i> <i>Edgewater, Md.</i>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                           | 22b. DATE THEREOF <i>Mar 4-1961</i>  |  | 22c. NAME OF CEMETERY OR CREMATORY <i>Mayo Memorial Cent</i>   |  | 22d. LOCATION (City, town, or county) (State) <i>Mayo Md</i>          |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Joan M. Taylor</i> ADDRESS <i>Annapolis Md.</i>   |                           |  |  | 24a. REC'D BY REGISTRAR DATE <i>MAR 6 '61</i>  |  | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2613  
CERTIFICATE OF DEATH  
02593

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>           |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>5 yrs. 7mo. 19 days</b>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>  |  |   |  | e. STREET ADDRESS<br><b>27 N. Carey Street</b>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Garrison</b> Middle <b>Cummings</b> Last <b>Cummings</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>4</b> Year <b>1961</b>  |  |  |  |
| 5. SEX<br><b>Male,</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/1/1875</b>                                   |  |
| 9. AGE (In years last birthday)<br><b>85 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>19</b>   |  | IF UNDER 24 HRS.<br>Hours <b>19</b> Min. <b>19</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Waiter</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>John Cummings</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth ?</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Paralytic Ileus</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Incarcerated Inguinal Hernia</b><br>(a), stating the underlying cause last. } DUE TO<br>(c) |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Advanced Arteriosclerotic Cardiovascular Disease with old myocardial infarction</b>  |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>-----</b> p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>  |  | 20f. (City or town) (County) (State)<br><b>-----</b>                   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/15/1961</b> to <b>3/4/1961</b> that (I) (we) last saw the deceased alive on <b>3/4/1961</b> , and that death occurred at <b>12:45</b> from the causes and on the date stated above.   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Hildegard Heard Reissman</b>  |  |   |  | 22b. DATE<br><b>3/6/61</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Hildegard Heard Reissman, M. D.</b> |  |
| 22d. ADDRESS<br><b>Crownsville State Hospital, Md.</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>3/10/61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles K. Lane</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>862 Bradman ave</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>                   |  |
| DATE <b>MAR 9 '61</b>  |  |   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02594

|  |                                  |   |   |  |  |   |  |
|--|----------------------------------|---|---|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>  |                                  |   |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |                                  |   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>RURAL - Churchton</u>   |  |   |  |
| c. LENGTH OF STAY IN TB<br><u>8 days</u>   |                                  |   |   | d. STREET ADDRESS<br><u>1</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Anne Arundel General Hospital</u>   |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Melvin</u>  |                                  | First Middle Last<br><u>DASHIELLS</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>March 25 1961</u>   |  |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>NEGro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>September 15, 1912</u>   | 9. AGE (In years last birthday)<br><u>48 yrs.</u>  | IF UNDER 1 YEAR<br>Months Days                                   | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>MARYland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                      |   |  |
| 13. FATHER'S NAME<br><u>Perry Dashiells</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Macklin Kane</u>   |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  |   | 16. SOCIAL SECURITY NO.<br><u>212-144-026</u>   |  | 17. INFORMANT<br>Address<br><u>Rosie Dashiells Churchton Md.</u> |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas &amp; metastases</u><br>157X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last, DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>18 months</u> |                                  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br><u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (the undersigned) attended the deceased from <u>Mar. 17, 1961</u> to <u>Mar. 25, 1961</u> , that (I) <u>did</u> last saw the deceased alive on <u>Mar. 25, 1961</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.  |                                  |   |   |  |  |   |  |
| 22a. SIGNATURE<br><u>Willard F. Smith</u> M.D.   |                                  |   |   | ATTENDING MED. STAFF<br>PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/>                     |  | 22b. DATE SIGNED<br><u>3/27/61</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Willard Smith</u>   |                                  |   |   | 22d. ADDRESS<br><u>Shadyside, Md.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>3-30-1961</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Siger</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Union Station Md.</u>                          |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>William Reese</u>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>MAR 30 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2615

## CERTIFICATE OF DEATH

Item 7 Film G283 3/23/61 iwk

02595

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission)<br>e. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b>              |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>3 days</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Crownsville</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>William B. DAWSON</b>  |                                  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>15</b> Year <b>1961</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 25, 1884</b> |
| 9. AGE (In years last birthday)<br><b>76 yrs.</b>   |                                  | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ret.</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>"UNK"</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>"UNK"</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>NO</b>   |  |
| 17. INFORMANT<br><b>HOWARD B. DAWSON</b>  |                                  | Address<br><b>#2</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive gastrointestinal hemorrhage</b><br><b>541.0</b><br>DUE TO (b) <b>Decedental ulcer</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>2 weeks</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. p.m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>         |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (the undersigned) attended the deceased from <b>Mar. 12, 1961</b> to <b>Mar. 15, 1961</b> , that (I) <b>did</b> last saw the deceased alive on <b>Mar. 15, 1961</b> , and that death occurred at <b>10:30 P.M.</b> M, from the causes and on the date stated above.  |                                  |  |  |
| 22a. SIGNATURE<br><b>Richard N. Peeler</b>  |                                  | 22b. DATE SIGNED<br><b>Mar. 15, 1961</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard N. Peeler</b>  |                                  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>3-18-61</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALDWIN MEMORIAL</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>CROWNSTVILLE MD.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Lofgren &amp; Sons</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>MAR 20 1961</b>  |  |
| ADDRESS<br><b>Annapolis, Md.</b>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |

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Handwritten notes and stamps, including dates like 10:30 P.M., 11:15, and 11:30, and names like Richard H. Baejer. The text is mostly illegible due to fading and bleed-through.

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| Item 21 Film 283 3-28-61   |  |  |  |   |   |   |  |   |  |
|--|--|--|--|---|---|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |   |   |   |  |   |  |
| 2616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |   |  |
| 1. PLACE OF DEATH<br>e. COUNTY <u>A. A. C. O.</u> MARYLAND   |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>ANCO</u>     |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |  |  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Millersville</u>                               |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>O. O. A. Anne Arundel General</u>   |  |  |  |   | d. STREET ADDRESS<br><u>Rt. 2 - Box 86</u>  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Ellis Ward Dillon</u>  |  |  |  |   | 4. DATE OF DEATH<br>Month <u>3</u> Day <u>5</u> Year <u>1961</u>  |   |  |   |  |
| 5. SEX<br><u>M</u>   |  | 6. COLOR OR RACE<br><u>W</u>                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>9-8-60</u>               |  | 9. AGE (In years last birthday) <u>1</u> yrs. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore Md</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u> |  |   |  |
| 13. FATHER'S NAME<br><u>Ellis Ward Dillon</u>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Loretta Fern Stacy</u>   |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  |  |  |   | 16. SOCIAL SECURITY NO.<br><u>Ellis W. Dillon</u>   |   | 17. INFORMANT<br><u>Ellis W. Dillon</u> Address <u>(2)</u>             |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>924.0</u> DUE TO <u>asphyxia</u><br>Conditions, if any, which gave rise to immediate cause (b) <u></u><br>(a), stating the underlying cause last. (c) <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> |  |  |  |   |   |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |   |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Clashed one subject over fence</u> |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>8.00</u> p.m. <u>3-5-1961</u>   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>   |   | 20f. (City or town) (County) (State)<br><u>ANCO MD</u>                 |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>          |  |  |  |   |   |   |  |   |  |
| ACTUAL SIGNATURE <u>E. Linhardt</u>  |  |  |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  |   |  |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u>  |  |  |  |   | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  |   |  |
|  |  |  |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |  |   |  |
|  |  |  |  |   | Address (Street, city, town, or county)<br><u>3/5/61</u>  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |  | 22b. DATE THEREOF<br><u>3-7-1961</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Hillcrest Memorial</u>   |   | 22d. LOCATION (City, town, or country) (State)<br><u>Annapolis Md.</u> |   |  |
| 23. FUNERAL DIRECTOR<br><u>John M. Layton Sons</u>   |  |  |  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>MAR 7 '61</u>  |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Kraus</u>                   |   |  |

2033191 X V4

02590

MISSOURI STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS - 1000 SOUTH STREET, ST. LOUIS, MO. 63102  
2016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE  
OF MISSOURI



Jan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2617  
CERTIFICATE OF DEATH

02597

|  |  |                                  |  |   |  |  |  |  |  |                                   |  |   |  |   |  |
|--|--|----------------------------------|--|---|--|--|--|--|--|-----------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b><br>c. LENGTH OF STAY IN 1b<br><b>2mo. 15 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Crownsville State Hospital</b>         |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>e. STATE<br><b>Maryland</b><br>f. COUNTY<br><b>Baltimore City</b><br>g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>h. STREET ADDRESS<br><b>806 Sharp Street</b><br>i. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                                   |  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Clarence</b><br>First<br><b>Dixon</b><br>Last   |  |                                  |  | 4. DATE OF DEATH<br>Month<br><b>3</b><br>Day<br><b>27</b><br>Year<br><b>1961</b>  |  |  |  |  |  |                                   |  |   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>August 20, 1904</b>   |  | 9. AGE (In years last birthday)<br><b>56</b> yrs.                      |  | IF UNDER 1 YEAR<br>Months<br>Days |  | IF UNDER 24 HRS.<br>Hours<br>Min.                           |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck Driver</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-----</b>   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |  |                                   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>               |  |   |  |
| 13. FATHER'S NAME<br><b>Charles Dixon</b>  |  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>Georgianna ?</b>   |  |  |  |  |  |                                   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)  |  |                                  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>   |  | Address  |  |                                   |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cachexia</b><br>DUE TO (b) <b>Cancer Metastases in Brain</b><br>DUE TO (c) <b>Bronchogenic Carcinoma</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                  |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                  |  |   |  |  |  |  |  |                                   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-----</b>  |  |  |  |  |  |                                   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. -----<br>p.m. <b>19</b>   |  |                                  |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work <input type="checkbox"/> While <input type="checkbox"/> at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b> |  | 20f. (City or town)<br><b>-----</b>                                    |  | (County)<br><b>-----</b>          |  | (State)<br><b>-----</b>                                     |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> to <b>3/27</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/27</b> , 19 <b>61</b> , and that death occurred at <b>8:20</b> P.M., from the causes and on the date stated above.   |  |                                  |  |   |  |  |  |  |  |                                   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Hildegard Heard Reimsman</b><br>M.D.  |  |                                  |  | 22b. DATE<br><b>3/28/61</b>   |  |  |  | 22c. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>            |  |                                   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  |  | 23b. DATE THEREOF<br><b>4/6/61</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>McGowan Cemetery, Balt.</b>   |  |                                   |  | 23d. LOCATION (City, town or county) (State)<br><b>M.D.</b> |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Arthur S. Kline</b>   |  |                                  |  | 25a. REC'D BY REGISTRAR<br><b>APR 5 '61</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>                   |  |                                   |  |   |  |   |  |

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Arthur L. Friend

VR A15 (4)  
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28538

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 - by the funeral director, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2619

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02599

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b><br>c. LENGTH OF STAY IN 1b <b>6 yrs</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>United States Army Hospital</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Hanover</b><br>d. STREET ADDRESS <b>12 Mulberry Rd</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FRANCIS</b> Middle <b>EGAN</b> Last <b>EGAN</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>27</b> Year <b>19 61</b>   |  |  |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>Cau</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |  | 8. DATE OF BIRTH <b>March 17, 1897</b>   |  |
| 9. AGE (In years last birthday) <b>69</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>10</b> Hours <b>15</b> Min.  |  | 11. IF UNDER 24 HRS.<br>Months <b>6</b> Days <b>10</b> Hours <b>15</b> Min.  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Mass.</b>   |  |
| 13. FATHER'S NAME <b>Unknown</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>  |  | 16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>   |  | 17. INFORMANT <b>Daughter) Patricia Knefel</b> Address <b>Same as above</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Renal Failure</b><br>DUE TO <b>434.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Congestive heart failure + pneumonia</b><br>DUE TO <b>Three Days</b><br>(c) <b></b> |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>One Day</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis and severe malnutrition</b>   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>24 March, 1961</b> , to <b>27 March, 1961</b> , that (I) <del>last</del> saw the deceased alive on <b>27 March 1961</b> , and that death occurred at <b>3:15 PM</b> from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| 22a. SIGNATURE <b>Nathaniel S. Beard</b>   |  |   |  | 22b. DATE <b>27 Mar '61</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>NATHANIEL S. BEARD, Capt., M.C.</b>  |  |   |  | 22d. ADDRESS <b>USA Hosp Ft Geo G. Meade, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMAINS SPECIFY <b>Buried</b>  |  | 23b. DATE THEREOF <b>March 30 - 61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Fort George G. Meade</b>   |  | 23d. LOCATION (City, town, county) (State) <b>Arlyle Va</b>                                    |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Blund G. Fink</b>  |  |   |  | 25a. REC'D BY REGISTRAR <b>Blund G. Fink</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Fink</b>   |  |

032900

CERTIFICATE OF DEATH

032900

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2620

## CERTIFICATE OF DEATH

Reg. Dist. No. 02600

|   |                        |  |   |
|---|------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY ANNE ARUNDEL MARYLAND  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MARYLAND b. COUNTY ANNE ARUNDEL                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS  |                        | c. LENGTH OF STAY IN 1b 52 DAYS  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND   |                        | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last Lois (n) EICHLER  |                        | 4. DATE OF DEATH Month Day Year MARCH 14 19 61   |   |
| 5. SEX FEMALE   | 6. COLOR OR RACE CAUC. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-26-1908                  |
| 9. AGE (In years lost birthday) 52 yrs.   |                        | 10. IF UNDER 1 YEAR Months Days Hours Min.   | 11. IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |                        | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country) North Carolina  |                        | 12. CITIZEN OF WHAT COUNTRY? United States   |   |
| 13. FATHER'S NAME RIVES, French Davis   |                        | 14. MOTHER'S MAIDEN NAME ATERHOLT, Inez (n)  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)  |                        | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT Address (Husband) Herman T. EICHLER, Shady Side, Md.  |                        |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Asystole<br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction<br>DUE TO (c)   |                        | INTERVAL BETWEEN ONSET AND DEATH None<br>8 Weeks   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                        | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19  |                        | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                        | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from 21 January, 19 61, to 14 March, 19 61, that I last saw the deceased alive on 14 March, 19 61, and that death occurred at 8:20A.M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE Sylvan Busch M.D. 14 March 1961<br>PHYSICIAN'S NAME (Type) Sylvan BUSCH, LT MC USNR U.S. Naval Hospital, Annapolis, Maryland |                        |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 3-17-61   |                        | 22b. DATE THEREOF  |   |
| 22c. NAME OF CEMETERY OR CREMATORY Oakwood Cem. Statesville NC  |                        | 22d. LOCATION (City, town, or county) (State)  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lee FUNERAL HOME WASH, D.C.  |                        | 24a. REC'D BY REGISTRAR DATE MAR 16 '61  |   |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Knead  |                        |  |   |

CERTIFICATE OF DEATH

1920

|                        |  |                        |  |
|------------------------|--|------------------------|--|
| NAME - DECEASED        |  | HUSBAND                |  |
| AGE                    |  | DATE OF BIRTH          |  |
| SEX                    |  | RACE                   |  |
| EDUCATION              |  | OCCUPATION             |  |
| MARRIED                |  | DATE OF MARRIAGE       |  |
| PLACE OF BIRTH         |  | PLACE OF DEATH         |  |
| DATE OF DEATH          |  | TIME OF DEATH          |  |
| CAUSE OF DEATH         |  | MANNER OF DEATH        |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  |
| DATE OF SIGNATURE      |  | DATE OF SIGNATURE      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G283 3/27/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

02601

|   |                                      |  |   |
|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>GA Co</u> <u>md</u> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>GA Co</u>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Glen Burnie md</u>  |                                      | c. LENGTH OF STAY IN 1b <u>X</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                      | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie md</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>KENNETH</u> First <u>FARBER</u> Middle <u>J</u> Last   |                                      | 4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1961</u>   |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 26</u> <u>1908</u>  |
| 9. AGE (In years last birthday) <u>52</u> yrs.  |                                      | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY <u>Depart store</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Ohio</u>   |                                      | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>James B Farber</u>   |                                      | 14. MOTHER'S MAIDEN NAME <u>Mary Minard</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                                      | 16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Richard E. Farber</u> Address <u>609 Stanton Rd.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>784.5</u> <u>Gastric Hemorrhage</u><br>DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> (c) <u></u> |                                      | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |                                      | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>   |                                      | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>October</u> , 19 <u>57</u> , to <u>MARCH</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>MARCH 13</u> , 19 <u>61</u> , and that death occurred at <u>230 P</u> M, from the causes and on the date stated above.                        |                                      |  |   |
| ACTUAL SIGNATURE <u>C. R. MacDonald M.D.</u> M.D.   |                                      | ADDRESS (Street, city or town, state) <u>204 Cram Hwy So</u> DATE SIGNED <u>3-20-61</u>  |   |
| PHYSICIAN'S NAME (Type) <u>C. R. MACDONALD M.D.</u>   |                                      | <u>Glen Burnie Maryland</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   | 22b. DATE THEREOF <u>March 22-61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie</u>  | 22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy Glen Burnie G.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G Frink</u> ADDRESS <u>Glen Burnie GA Co md</u>   |                                      | 24a. REC'D BY REGISTRAR <u>Mar 22 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>   |   |



1

2622

CERTIFICATE OF DEATH

02602

|  |                               |  |                                     |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>A. A. Co.</b>             |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>A. A. GENERAL HOSPT.</b>  |                               | d. STREET ADDRESS <b>714 SPRINGDALE AVE</b>  |                                     |
| 3. NAME OF DECEASED (Type or print) <b>JOHN C. FERGUSON</b>  |                               | 4. DATE OF DEATH <b>MAR 25 1961</b>  |                                     |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>NOV 15 1909</b> |
| 9. AGE (In years last birthday) <b>51</b> yrs.   |                               | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Mech. P.W.O.</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Naval Academy</b>   |                                     |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |                                     |
| 13. FATHER'S NAME <b>CHARLES FERGUSON</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>MARGARE KLEIN</b>  |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                               | 16. SOCIAL SECURITY NO.  |                                     |
| 17. INFORMANT <b>EMMA R. FERGUSON #2</b>   |                               | Address  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>022X</b> <b>Coronary Artery</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 60</b> to <b>3-25</b> 1961, that (I) (we) last saw the deceased alive on <b>3-25</b> 1961, and that death occurred at <b>11:30</b> P.M. from the causes and on the date stated above.  |                               |  |                                     |
| 22a. SIGNATURE <b>E. L. Linhart</b>  |                               | 22b. DATE <b>3/26/61</b>   |                                     |
| 22c. PHYSICIAN'S NAME (Type) <b>E. L. Linhart</b>  |                               | 22d. ADDRESS <b>Annapolis Md</b>   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3/29/61</b>   |                               | 23b. DATE THEREOF  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY <b>GRANITE PRES. CEM.</b>   |                               | 23d. LOCATION (City, town, or county) (State) <b>GRANITE MD.</b>   |                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR SONS</b>  |                               | 25a. REC'D BY REGISTRAR <b>MAR 28 '61</b>  |                                     |
| ADDRESS <b>ANNAPOLIS MD</b>  |                               | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |                                     |

802 So

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 286 5-1-62 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2623

CERTIFICATE OF DEATH

02603

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort George G. Meade</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>5 months</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Army Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JANET</b> Middle <b>ALICE</b> Last <b>FINCHER</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>13</b> Year <b>19 61</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Mon /Cau</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>24 Oct 1960</b>  |  |
| 9. AGE (In years lost birthday) yrs.<br><b>4</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>20</b>   |  | 11. IF UNDER 24 HRS.<br>Hours <b>20</b> Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>-</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>James A Fincher</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mutsuko Kaminae</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>-</b>  |  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT<br><b>(Father) Qtrs 7201-D Ft Geo G. Meade, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cause unknown / Broncho pneumonia, Bilateral,</b><br>DUE TO <b>Etiology Klebsiella Aerobacter Group. Pulmonary</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>congestion and edema, bilateral, marked.</b><br>DUE TO (c) <b>-</b> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unk</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <b>20</b> (this hospital) <b>examined</b> the deceased from <b>19 13 March 19 61</b> and that death occurred at <b>12:38 PM</b> from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Sherman S. Robinson</b>  |  |   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>13 Mar 61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>SHERMAN S. ROBINSON, Capt., M.C.</b>   |  |   |  | 22d. ADDRESS<br><b>US Army Hosp Ft Geo G. Meade, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>March 14, 1961</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Balt. National</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>                             |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>DelWith Donaldson</b>  |  |   |  | ADDRESS<br><b>Lanell, Md</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 23 '61</b>   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |   |  |

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THE STATE OF TEXAS,  
COUNTY OF DALLAS,  
I, the undersigned, Clerk of the County Court,  
do hereby certify that the within and foregoing  
is a true and correct copy of the original  
as the same appears from the records of the  
County Court of Dallas County, Texas.  
Witness my hand and the seal of said County Court  
this 1st day of January, 1900.  
Clerk of the County Court.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2624

02604

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum Heights</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>38 yrs.</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>500 Cleveland Road</u>  |  |  |  | d. STREET ADDRESS <u>1500 Cleveland Road</u>   |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur W. Fletcher</u>   |  |  |  | 4. DATE OF DEATH Month Day Year <u>March 17 1961</u>   |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>MARCH 19-1883</u> 77 yrs.                            |  |
| 9. AGE (In years lost birthday) <u>77</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS. Months Days Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ticket Agent (ret)</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Balto &amp; Ohio R.R.</u>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Rockville, Maryland</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  |
| 13. FATHER'S NAME <u>Arthur H. Fletcher</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Julia M. Wadsworth</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>20-69-6921</u>  |  |  |  |
| 17. INFORMANT Address <u>Same as</u>  |  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u><br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>5-year</u><br>DUE TO (c) <u>5-year</u> |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>March 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 17, 1961</u> , and that death occurred at <u>29 M.</u> from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>James S. Billingsley</u>  |  |  |  | 22b. DATE SIGNED <u>March 18, 1961</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>James S. Billingsley</u>  |  |  |  | 22d. ADDRESS <u>108 Central Ave Glen Burnie Md.</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>3-20-1961</u>     |  | 23c. NAME OF CEMETERY OR CREMATORY <u>meadow ridge memorial Park</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>Howard Co. Maryland</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Doughton</u>   |  |  |  | 25a. REC'D BY REGISTRAR <u>Glen Burnie, Maryland</u>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>   |  |  |  | DATE <u>MAR 21 '61</u>   |  |  |  |

may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05600

CERTIFICATE OF DEATH

2088

(M)

First name and surname of deceased  
see above and name of deceased  
Archibald, Mr. Fletcher  
I hereby certify that the above named  
person died on the 11th day of March 1922 at  
the residence of the deceased, 121st  
Avenue, in Fletcher  
County, Minnesota, at the age of  
years, and that the cause of death was  
disease of the heart.

Witness my hand and seal of office  
this 11th day of March 1922 at  
St. Paul, Minnesota.  
J. H. [Signature]  
Registrar of Deaths  
State of Minnesota

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2625

02605

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>AA</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b><br>c. LENGTH OF STAY IN 1b <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b><br>b. COUNTY <b>A.A.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Reisterstown</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8489 Arbutus Rd</b>   |   | d. STREET ADDRESS <b>8489 Arbutus Rd</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Thomas</b> Middle <b>G.</b> Last <b>Ford</b>  |   | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>21</b> Year <b>1961</b>  |  |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>1-19-02</b>                                  |
| 9. AGE (In years lost birthday) <b>59</b> yrs.  |   | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)   |   | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME <b>Emil Ford</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Lucietta Johnson</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |   | 16. SOCIAL SECURITY NO. <b>-</b>   |  |
| 17. INFORMANT <b>Family</b>   |   | Address <b>Same</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the right lung</b><br>163X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><b>Generalized hypertrophic osteoarthritis</b> |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                             |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 22, 1960</b> to <b>Mar. 21, 1961</b> that (I) (we) last saw the deceased alive on <b>Mar. 19, 1961</b> , and that death occurred at <b>1500 AM</b> from the causes and on the date stated above.  |   |  |  |
| 22a. SIGNATURE <b>R. M. McLaughlin</b>  |   | 22b. DATE SIGNED <b>3/21/61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>R. M. McLaughlin</b>  |   | 22d. ADDRESS <b>3708 Mountain Rd. Pasadena, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>  | 23b. DATE THEREOF <b>3-24-61</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowdale Cem.</b>  | 23d. LOCATION (City, town, or county) (State) <b>Elkridge MD</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>McCurly Funeral Home</b>  |   | 25a. REC'D BY REGISTRAR <b>MAR 23 '61</b>  |  |
| ADDRESS <b>130 E Fort Ave</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>   |  |

MEDICAL CERTIFICATION

05008

DEATH CERTIFICATE

05008

1.1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

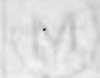
FOR STATE  
HEALTH DEPT.

V5. A15ME  
5M 3/59

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  |  |  |  |
|--|--|--|--|--|--|--|--|
| a. COUNTY  |  |  |  | a. STATE   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   |  |  |  | b. COUNTY  |  |  |  |
| c. LENGTH OF STAY IN 1b  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |  |  | d. STREET ADDRESS  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Millersville</b><br>c. LENGTH OF STAY IN 1b<br><b>6 months</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Box 60 Route 3</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Same</b><br>b. COUNTY<br><b>Same</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Same</b><br>d. STREET ADDRESS<br><b>Same</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Gilbert Gene Gartelman</b>  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>March 27th. 19 61</b>   |  |  |  |
| 5. SEX<br><b>M.</b>  |  |  |  | 6. COLOR OR RACE<br><b>W.</b>  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 8. DATE OF BIRTH<br><b>9/8/60</b>  |  |  |  |
| 9. AGE (In years last birthday)<br>yrs. <b>6</b> Months <b>19</b> Days <b>19</b>   |  |  |  | 10. AGE (In years last birthday)<br>yrs. <b>6</b> Months <b>19</b> Days <b>19</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore, Md.</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>Gilbert James Gartelman</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Doris Marie Frazier</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>The parents.</b>   |  |  |  |
| 17. INFORMANT<br><b>The parents.</b>   |  |  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pulmonary infection.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. (c)<br><b>527.2</b>  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Few hours.</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Gustave H. Faubert</b>  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| EXAMINER'S NAME (Type)<br><b>Gustave H. Faubert, M.D.</b>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  | DATE SIGNED<br><b>3/27/61</b>  |  |  |  |
| Address (Street, city, town, or county)<br><b>Glen Burnie, Md.</b>   |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  | 22b. DATE THEREOF<br><b>28<sup>th</sup> March 61</b>   |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cem.</b>   |  |  |  | 22d. LOCATION (City, town, or country) (State)<br><b>Glen Burnie, Md.</b>  |  |  |  |
| 23. FUNERAL DIRECTOR<br><b>R. J. Singleton</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br><b>Glen Burnie, Md.</b>   |  |  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>R. J. Singleton</b>   |  |  |  | DATE<br><b>MAR 28 '61</b>  |  |  |  |

2043202XV5



name of

Albanyville

6 months

same

Box 50 Route 7

Gilbert Gene Garrison

5/8/60

6 19

USA

Albanyville, N.Y.

Gilbert Gene Garrison

Box 50 Route 7

The parents.

Acute pulmonary infection.

X

X

3/2/61

X

Gilbert Gene Garrison

Gilbert Gene Garrison

1  
2626

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02606

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>          |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>   |  |   |  | c. LENGTH OF STAY IN 1b <u>Life</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 12 Ridge Road</u>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Erma</u> Middle <u>R.</u> Last <u>German</u>   |  |   |  | 4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1961</u>  |  |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>                 |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>2 August 1880</u>                                    |  |
| 9. AGE (In years lost birthday) <u>80</u> yrs.  |  | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> |  | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>         |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <u>George L. Sherwood</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Emmit R. Love</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>None</u>           |  | 17. INFORMANT Address <u>Mr. Joeseeph L. German Jr.</u>  |  | Same as # 2  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>422.1</u> IMMEDIATE CAUSE (a) <u>chr Myocarditis</u><br>DUE TO <u>6mo</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u><br>DUE TO <u>9yrs</u><br>(c) <u>confermatives of age</u> <u>59yrs</u> |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.  |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1960</u> to <u>March 1961</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>March 1 1961</u> , and that death occurred at <u>10 M.</u> from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| 22a. SIGNATURE <u>B B Brumbaugh</u> M.D.  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <u>3/3/61</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>   |  |   |  | 22d. ADDRESS <u>5609 Main St Elberton Md</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>3-Mar. 1961</u>          |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>Howard Co. Maryland</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>A V Singleton</u> ADDRESS <u>Glenn Burns, Md.</u>   |  |   |  | 25a. REC'D BY REGISTRAR <u>Mar 6 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>                        |  |

03500

CERTIFICATE OF DEATH

03500

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
2628  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02608

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 yrs. 9 mos. 9 days</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Crownsville State Hospital</b>   |  |   |  | d. STREET ADDRESS<br><b>Unknown</b>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Ruby</b> Middle <b>Elizabeth</b> Last <b>Green</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>20</b> Year <b>19 61</b>  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>7/28/27</b>                                     |  |
| 9. AGE (In years last birthday)<br><b>33</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Maryland U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>Frank Green</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rebecca ?</b>                           |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Torula Meningitis 134.1</b><br><b>134.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO<br>causing the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                                       |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br>-----  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>am</b> <b>19</b> p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>factory, street, office bldg., etc.</b>  |  | 20f. (City or town) (County) (State)<br>-----                          |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>58</b> to <b>3/20</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/20</b> , 19 <b>61</b> , and that death occurred at <b>11:30</b> from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Hildegard H. Reissmann, M.D.</b>   |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>3/21/61</b>                                     |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Hildegard H. Reissmann, M.D.</b>   |  |   |  | 22d. ADDRESS<br><b>Crownsville State Hospital, Maryland</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>3/24/61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shilo Methodist</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Shilo, Md.</b>      |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rehman Funeral Home, La B. Pk., Md.</b>  |  |   |  | ADDRESS<br><b>La B. Pk., Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>APR 7 '61</b>                       |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |  |  |

105008

2038

Charles

Harland

Anna Arnold

Harland

2 mos. 9 days

Cromwell

Unknown

Cromwell State Hospital

Green

Elizabeth

Ruby

7/28/27

x

Regis

Female

Harland

Harland

Unknown

Cromwell

Robert

Frank Green

Harland

Unknown

to

at

7/20

58

7/20

at

7/20

7/20

7/20

x

Midgard H. Peterson, M.D., Cromwell State Hospital, Harland

1  
M  
I  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2629  
CERTIFICATE OF DEATH  
02609

|  |  |                                  |  |   |  |   |  |
|--|--|----------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b> MARYLAND   |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b> b. COUNTY<br><b>Anne Arundel</b>       |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |                                  |  | c. LENGTH OF STAY IN b.<br><b>21 days</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>   |  |                                  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Annapolis</b>  |  |   |  |
| d. STREET ADDRESS<br><b>Severn Forest Ave.,</b>  |  |                                  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mabel</b>   |  | First<br><b>Mabel</b>            |  | Middle<br><b>GRIFFIN</b>  |  | Last<br><b>GRIFFIN</b>                  |  |
| 4. DATE OF DEATH<br><b>March 6 1961</b>  |  | Month<br><b>March</b>            |  | Day<br><b>6</b>   |  | Year<br><b>1961</b>                     |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb. 3, 1877</b> |  |
| 9. AGE (In years last birthday)<br><b>84 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days   |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>New Hampshire</b>  |  |                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>R. FOREST TOLLE</b>  |  |                                  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELMA GORDON</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>-</b>  |  |                                  |  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |  |   |  |
| 17. INFORMANT<br><b>George Faldmann</b><br><b>Severn Forest, Annapolis Md.</b>   |  |                                  |  | Address<br><b>Severn Forest, Annapolis Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Artery Thrombosis</b><br><b>332X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) |  |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks.</b>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Bronchopneumonia</b>   |  |                                  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |                                  |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) (In hospital) attended the deceased from <b>Feb. 13, 1961</b> to <b>Mar. 6, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Mar. 6, 1961</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.  |  |                                  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Richard N. Peeler</b><br>M.D.   |  |                                  |  | 22b. DATE SIGNED<br><b>3/6/61</b>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard N. Peeler</b>   |  |                                  |  | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  |  | 23b. DATE THEREOF<br><b>Mar 10-61</b>   |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>North Tanwalle Cent</b>   |  |                                  |  | 23d. LOCATION (City, town or county) (State)<br><b>Tanwalle N. H.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Saylor</b><br>Sons  |  |                                  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 10 '61</b>  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>   |  |                                  |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |  |  |  |  |  |  |  |  |  |
|---|--|-------------------------------|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |  |  |  |  |  |  |  |  |  |
| 2630 CERTIFICATE OF DEATH 02610   |  |                               |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>a a Co -</u> MARYLAND   |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>a a Co.</u> |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>annapolis</u>   |  |                               |  | c. LENGTH OF STAY IN lb <u>6 hours -</u>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Deale</u>  |  |  |  | d. STREET ADDRESS <u>Highview Nutwell A.A. Co.</u>             |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Amie Brunel General Hospital</u>  |  |                               |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Frederick</u>  |  |                               |  |  |  | 4. DATE OF DEATH <u>March 25 1961</u>  |  |  |  |  |  |
| 5. SEX <u>male</u>  |  | 6. COLOR OR RACE <u>white</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Oct 8, 1891</u>  |  | 9. AGE (In years last birthday) <u>69</u> yrs.     |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE STA.</u>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN. BUSINESS</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>SOMMERVILLE N.J.</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                     |  |
| 13. FATHER'S NAME <u>PAUL GUEST</u>   |  |                               |  |  |  | 14. MOTHER'S MAIDEN NAME <u>MARTHA. LEHMAN.</u>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or date of service)   |  |                               |  |  |  | 16. SOCIAL SECURITY NO. <u>218-32-2321</u>   |  |  |  |  |  |
| 17. INFORMANT <u>NELLIE GUEST.</u>  |  |                               |  |  |  | Address <u>HIGHVIEW NUTWELL</u>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                               |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u>  |  |                               |  |  |  |  |  |  |  |  |  |
| 541.0 DUE TO (b) <u>coronary artery disease</u>   |  |                               |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>Blistering duodenal ulcer.</u>   |  |                               |  |  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                               |  |  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                               |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |  |  |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                               |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |                               |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)               |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 25, 1961</u> to <u>March 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 25, 1961</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above. |  |                               |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>Emily H. Lehman</u>   |  |                               |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |  | 22b. DATE SIGNED <u>3-26-61</u>                    |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Lothian, Md</u>   |  |                               |  |  |  | 22d. ADDRESS   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  |                               |  | 23b. DATE THEREOF <u>MARCH 30, 1961</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>MORELAND</u>   |  |  |  | 23d. LOCATION (City, town or county) (State) <u>BELAIR MD.</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home 7401 Belair Road #6.</u>   |  |                               |  |  |  | 25a. REC'D BY REGISTRAR <u>APR 3 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hennes</u> |  |  |  |

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## CERTIFICATE OF DEATH

Reg. Dist. No. 02611

|   |                                       |  |  |
|---|---------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                       | c. LENGTH OF STAY IN 1b<br><b>25 yrs.</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>19 Morris Street</b>   |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Florence</b> Middle <b>Warren</b> Last <b>Hall</b>  |                                       | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>29</b> Year <b>19 61</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Colored</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 27-1870</b>   |
| 9. AGE (In years last birthday)<br><b>90</b> yrs.   |                                       | 10. IF UNDER 1 YEAR<br>Months <b>90</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   | 11. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Annapolis, Maryland</b>   |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>George Warren</b>   |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth ?</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                       | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |
| 17. INFORMANT<br><b>Margaret Grooms - 19 Morris St. Anna. Md.</b>   |                                       | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Coronary atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Varicose veins</b> DUE TO <b>Quadrant 9</b><br>(c) <b>9 yrs.</b> |                                       | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>  |                                       | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                       | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                     |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                       | 20f. (City or town) (County) (State)   |  |
| 21. I certify that attended the deceased from <b>Oct 15, 1959</b> to <b>3/29/61</b> , that I last saw the deceased alive on <b>3/29/61</b> , 19 <b>61</b> , and that death occurred at <b>110 Clay St.</b> from the causes and on the date stated above.  |                                       | ADDRESS (Street, city or town, state) DATE SIGNED  |  |
| ACTUAL SIGNATURE <b>R.L. Richardson</b> M.D.  |                                       | <b>110 Clay Street - Annapolis, Md.</b>  |  |
| PHYSICIAN'S NAME (Type) <b>R.L. Richardson</b>  |                                       |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Apr. 2-61</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Asbury</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Md.</b>             |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.E. HICKS</b>   |                                       | ADDRESS<br><b>111 Annapolis, Maryland</b>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>APR 4 '61</b>  |                                       | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. ...</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES DEPARTMENT OF AGRICULTURE

1933

Annual Report of the  
Bureau of Plant Industry  
for the year 1932  
Washington, D. C.  
1933

Published by the  
Government Printing Office  
Washington, D. C.  
1933

For sale by the  
Government Printing Office  
Washington, D. C.  
1933

Price, \$1.00 per copy

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |   |  |   |   |   |   |   |  |         |
|---|--|-------------------------------|---|--|---|---|---|---|---|--|---------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |   |  |   |   |   |   |   |  |         |
| 2632  |  |                               |   |  | CERTIFICATE OF DEATH  |   |   |   |   | 02612  |         |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b><br>c. LENGTH OF STAY IN b. <b>1 yr 2 mos. 20 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>   |  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore City</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>909 Shields Place</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |   |  |         |
| 3. NAME OF DECEASED<br>(Type or print) <b>Elizabeth (Hairston) Harrison</b>   |  |                               |   |  | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>12</b> Year <b>1961</b>   |   |   |   |   |  |         |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>Negro</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>1904</b>  |   | 9. AGE (In years last birthday) <b>56</b> yrs.            |   | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>12</b> Hours <b>12</b> Min. |         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>  |  |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>   |   | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> |   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>        |  |         |
| 13. FATHER'S NAME <b>Unknown</b>  |  |                               |   |  | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>   |   |   |   |   |  |         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |                               | 16. SOCIAL SECURITY NO. <b>Unknown</b>  |  | 17. INFORMANT <b>Hospital Records</b>   |   |   | Address   |   |  |         |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b><br>DUE TO<br>(b) <b>Hypertensive Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Brain Syndrome asso. w. Cerebral Arteriosclerosis.</b> |  |                               |   |  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH                                       |         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |         |
| 20c. TIME OF INJURY<br>Hour <b>a.m.</b> Month, Day, Year <b>19</b><br>p.m.  |  |                               | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town)                       |   | (County)  |  | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/28/</b> , 19 <b>57</b> to <b>3/12/</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/12/</b> , 19 <b>61</b> , and that death occurred at <b>12:45</b> from the causes and on the date stated above.   |  |                               |   |  |   |   |   |   |   |  |         |
| 22a. SIGNATURE <b>Hildegard H. Reissmann, M.D.</b>  |  |                               |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>3/13/61</b>  |   |   | 22b. DATE SIGNED  |   |  |         |
| 22c. PHYSICIAN'S NAME (Type) <b>Hildegard H. Reissmann, M.D.</b>  |  |                               |   |  | 22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>  |   |   |   |   |  |         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |                               | 23b. DATE THEREOF <b>3/15/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>  |   |   | 23d. LOCATION (City, town or county) <b>Baltimore Md.</b> |   |  |         |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Marion H. Yett</b>  |  |                               |   |  | ADDRESS <b>916 Pennsylvania Ave</b>   |   | 25a. REC'D BY REGISTRAR <b>MAR 16 '61</b> |   | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b> |  |         |

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## CERTIFICATE OF DEATH

Reg. Dist. No. 02613

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Prince Arundel</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>35 Yrs.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1946 West Street</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Daisy Harried or Harrod</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>March 6 1961</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>Colored</b>        |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Aug. 10- 1897</b>                             |  |
| 9. AGE (In years last birthday) yrs.<br><b>63</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>A.A.Co. Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Lewis Butler</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Jones</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>215-16-9404</b>   |  |  |  |
| INFORMANT<br><b>Milburn Harried - 1946 West St. Anna. Md.</b>  |  |   |  | Address   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO <b>Arterio-sclerotic Hypertensive disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Arterio-sclerotic Hypertensive disease</b><br>DUE TO (c) <b>Arterio-sclerotic Hypertensive disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic Hypertensive disease</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 Weeks</b> |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |  |   |  |   |  |  |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  |   |  |  |  |
| 20f. (City or town) (County) (State)   |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>Jan 6, 1961</b> to <b>March 6, 1961</b> , that I lost saw the deceased alive on <b>March 6, 1961</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.   |  |   |  |   |  |  |  |
| ADDRESS (Street, city or town, state) <b>110 - Clay St. Annapolis, Md.</b> DATE SIGNED <b>3/9/61</b>   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>R.L. Richardson</b> M.D.   |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>R.L. Richardson</b> <b>110 Clay St. Annapolis, Md.</b>  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |   |  |   |  |  |  |
| 22b. DATE THEREOF <b>3-9-61</b>  |  |   |  |   |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Fowlers Chapel</b>   |  |   |  |   |  |  |  |
| 22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>  |  |   |  |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>C.E. Hicks 111 Annapolis, Maryland</b>  |  |   |  |   |  |  |  |
| 24a. REC'D BY REGISTRAR DATE <b>MAR 13 '61</b>   |  |   |  |   |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>   |  |   |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2023

2023

|                |              |                |              |
|----------------|--------------|----------------|--------------|
| First Name     | John         | Last Name      | Doe          |
| Sex            | Male         | Age            | 75           |
| Date of Birth  | 1948-03-15   | Date of Death  | 2023-01-10   |
| Place of Birth | New York, NY | Place of Death | New York, NY |
| Family Name    | Doe          | Family Name    | Doe          |
| Marital Status | Married      | Marital Status | Married      |
| Spouse's Name  | Jane Doe     | Spouse's Name  | Jane Doe     |
| Occupation     | Retired      | Occupation     | Retired      |
| Signature      | [Signature]  | Signature      | [Signature]  |

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

1  
 2634  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

02614

|  |                               |  |  |   |  |  |  |
|--|-------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u><br>c. LENGTH OF STAY IN 1b <u>10 yrs.</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Conley Bldg. - Box 310x</u>   |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Anne Arundel</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Odenton</u><br>d. STREET ADDRESS <u>1 Conley Bldg. - Box 310x</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>C.</u> Last <u>Hart</u>   |                               | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>19</u> Year <u>1961</u>  |  |   |  |  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/4 June 1887</u> | 9. AGE (In years lost birthday) <u>73</u> yrs.  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Port Perry, Pennsy.</u>  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                               | 13. FATHER'S NAME <u>(Unknown) Slane</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Catherine Coyle</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT <u>Mrs. Louise Zomp</u> Address <u>June Drive, Odenton, Md.</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hypertensive Sclerotic Cardio Vascular</u><br>DUE TO (c) <u>Digene &amp; Cardiac Failure</u> |                               |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a. m.</u> <u>19</u><br>p. m.   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |
| 20f. (City or town) (County) (State)   |                               |  |  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> to <u>3/28</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3/24</u> , 19 <u>60</u> , and that death occurred at <u>12:00</u> AM, from the causes and on the date stated above.  |                               |  |  |   |  |  |  |
| 22a. SIGNATURE<br><u>Felice Frenkers MD</u>  |                               | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  | 22b. DATE SIGNED <u>3/20/61</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Felice Frenkers</u>  |                               | 22d. ADDRESS <u>P.O. Box 27 Odenton, Md.</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE THEREOF <u>23rd March '61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Braddock Catholic Cem.</u>  |  |  |  |
| 23d. LOCATION (City, town, or county) (State) <u>Braddock Pennsy.</u>  |                               |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>R. V. Singleton, Glen Burnie, Maryland</u>  |                               | 25a. REC'D BY REGISTRAR<br>DATE <u>MAR 21 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |  |  |  |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

(M)

(1)

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2635  
CERTIFICATE OF DEATH  
02615

|  |                                |   |   |
|--|--------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |                                | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort George G. Meade</b>  |                                | c. LENGTH OF STAY IN 1b<br><b>-</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U. S. Army Hospital</b>   |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>-</b> Middle <b>-</b> Last <b>HAYES</b>  |                                | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>3</b> Year <b>19 61</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>Cau</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> <b>N/A</b> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>2 March 1961</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>6</b>   |                                | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>58</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>-</b>  |                                | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>-</b>  |   |
| 13. FATHER'S NAME<br><b>Robert T Hayes</b>   |                                | 14. MOTHER'S MAIDEN NAME<br><b>Janice L. Crapser</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>-</b>   |                                | 16. SOCIAL SECURITY NO.<br><b>-</b>   |   |
| 17. INFORMANT<br>(Father) <b>604 S. Rappalla St Balto, Md.</b>   |                                | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b><br><b>774X</b> DUE TO <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>-</b><br>(c) <b>-</b> |                                | INTERVAL BETWEEN ONSET AND DEATH<br><b>-</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>   |                                | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-</b>  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b> p. m. <b>-</b>  |                                | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-</b>   |                                | 20f. (City or town) (County) (State)<br><b>-</b>  |   |
| 21. I certify that (I) <b>physician</b> attended the deceased from <b>6:30 PM 2 Mar 61</b> to <b>1:28 A</b> , 19 <b>3</b> , that (I) <b>324</b> last saw the deceased alive on <b>3 Mar 19 61</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.  |                                | 22a. SIGNATURE<br><b>George N. Schultz</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED<br><b>3 Mar 61</b> |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE N. SCHULTZ, M.D.</b>   |                                | 22d. ADDRESS<br><b>USA Hosp Ft Geo G. Meade, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>3 MAR 61</b>   |                                | 23b. DATE THEREOF<br><b>3 MAR 61</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>USA Hosp</b>  |                                | 23d. LOCATION (City, town, or county) (State)<br><b>Ft Geo G Meade, Md</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Shirley J. Lender - 24 MSC</b>  |                                | 25a. RECEIVED BY REGISTRAR<br><b>MAR 7 61</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                | 25c. DATE<br><b>-</b>   |   |

10380

3333

|                    |  |           |  |
|--------------------|--|-----------|--|
| PATIENT'S NAME     |  | DATE      |  |
| FATHER'S NAME      |  | AGE       |  |
| MOTHER'S NAME      |  | SEX       |  |
| ADDRESS            |  | CITY      |  |
| STATE              |  | ZIP       |  |
| OCCUPATION         |  | EDUCATION |  |
| RELIGION           |  | RACE      |  |
| MARITAL STATUS     |  | SINGLE    |  |
| PREVIOUS DENTISTRY |  | YES       |  |
| DENTAL HISTORY     |  | NO        |  |
| X-RAYS             |  | YES       |  |
| TREATMENT PLAN     |  | NO        |  |
| COST               |  | FREE      |  |
| PAYMENT            |  | CASH      |  |
| SIGNATURE          |  | DATE      |  |
| DENTIST            |  | CLINIC    |  |

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2636

02616

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Maryland</u>   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |   | c. LENGTH OF STAY IN 1b<br><u>10</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Anne Arundel General Hospital</u>   |   |   |   | d. STREET ADDRESS<br><u>8 Hill St.</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Alice</u> Middle <u>Irene</u> Last <u>HILPRECHT</u>  |   |   |   | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>22</u> Year <u>19 61</u>  |  |   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 21, 1906</u> | 9. AGE (In years last birthday)<br><u>55</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)<br><u>House wife</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |
| 13. FATHER'S NAME<br><u>John M. Vinson</u>   |   |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Claraissa V. Hirschburger</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>-</u>   |   | 17. INFORMANT<br><u>Karl Hilprecht</u><br>Address <u>  </u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Coarctation</u><br>DUE TO<br>(c) <u>Carcinomatosis - Stomach</u> |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4-5 6 wks.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |   |   |   |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)                       | (County)  | (State)  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21. I certify that (I) <u>this hospital</u> attended the deceased from <u>Jan. 25, 19 61</u> to <u>Mar. 22, 19 61</u> , that (I) <u>yes</u> last saw the deceased alive on <u>Mar. 22, 19 61</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.   |   |   |   |   |  |   |  |
| 22a. SIGNATURE<br><u>Stuart M. Christhlf, Jr., M.D.</u>  |   |   |   | 22b. DATE<br><u>3/24/61</u>   |  | 22c. ADDRESS<br><u>69 Franklin St., Annapolis, Md.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |   | 23b. DATE THEREOF<br><u>3-25-1961</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hillcrest Memorial</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Annapolis Md</u>                               |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Scaylor Sns</u>   |   |   |   | 25a. REC'D BY REGISTRAR<br><u>  </u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Thomas</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3280

305



I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |  |  |                |   |  |
|---|--|---|---|---|--|--|--|--|----------------|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |   |   |  |  |  |  |                |   |  |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |  |  |                |   |  |
| 2637  |  | Item 7 Film, 283, 3/27/61   |   |   |  | 1wk  |  | 02617  |                |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b>   |  |   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b> |  |  |                |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |   |   | c. LENGTH OF STAY IN 1b<br><b>20 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL - Millersville</b>  |  |  |                |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Anne Arundel General Hospital</b>  |  |   |   |   |  | d. STREET ADDRESS<br><b>1</b>  |  |  |                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>RICHARD</b>  |  |   | First Middle Last<br><b>Austin HUMRICKHOUSE</b> |   |  | 4. DATE OF DEATH<br><b>March 19 1961</b>   |  |  | Month Day Year |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>August 5, 1877</b>  |  | 9. AGE (In years last birthday)<br><b>83 yrs.</b>    |                | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plant Supervisor Battery Plant</b>  |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>West Virginia</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>U.S.</b>   |  |  |                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>SAMUEL P. HUMRICKHOUSE</b>  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>WILHELMINA WARNER</b>  |  |  |  | Address<br><b>EDNA S. KEEN 315 COVERD. RIVA MO</b>   |                |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |   |   | 16. SOCIAL SECURITY NO. (If yes give year or dates of service)  |  | 17. INFORMANT<br><b>EDNA S. KEEN 315 COVERD. RIVA MO</b>   |  |  |                |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Toxemia</b><br><b>422.1</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Gangrene, distal, lower extremity, left</b><br>DUE TO<br>(c) <b>Arteriosclerotic cardiovascular disease</b> |  |   |   |   |  |  |  |  |                | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks</b><br><b>2 mo</b><br><b>10 yrs.</b>                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |   |   |  |  |  |  |                |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>-</b>  |  |  |  |  |                |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m.<br>p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)  |  | (County)   |                | (State)   |  |
| 21. I certify that (I) <del>did not</del> attended the deceased from <b>Feb 27, 1961</b> to <b>Mar 19, 1961</b> , that (I) <del>not</del> saw the deceased alive on <b>Mar 18, 1961</b> , and that death occurred at <b>9:20 A.M.</b> from the causes and on the date stated above.   |  |   |   |   |  |  |  |  |                |   |  |
| 22a. SIGNATURE<br><b>Merton T. Waite</b>  |  |   |   | M.D.<br><b>Merton T. Waite</b>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED<br><b>3-19-61</b>                   |                |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Merton T. Waite</b>  |  |   |   | 22d. ADDRESS<br><b>121 Cathedral St., Annapolis, Md.</b>  |  |  |  |  |                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>3-23-61</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>W. LAUREL HILL</b>   |  | 23d. LOCATION (City, town or county)<br><b>PHILA.</b>  |  | (State)<br><b>PA.</b>                                |                |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. G. [Signature]</b>   |  |   |   | ADDRESS<br><b>Annapolis, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 22 '61</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b> |                |   |  |

11861

11861



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2638 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02618

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>   |   | c. LENGTH OF STAY IN 1b<br><u>25 yrs.</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>47 Northwest Street</u>   |   | d. STREET ADDRESS<br><u>47 Northwest Street</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Irven Thomas James</u>   |   | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>10</u> Year <u>1961</u>   |   |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>Colored</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><u>Apr. 9-1894</u>                                      |
| 9. AGE (In years last birthday)<br><u>66</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer - U.S. Naval Academy - Retired</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Annapolis, Maryland</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>William T. James</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Carrie S. Bias</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>Yes.</u> <u>W.W.I</u>   |   | 16. SOCIAL SECURITY NO.<br><u>Unknown</u>   |   |
| 17. INFORMANT<br><u>Richard I. James - 47 Northwest St. Anna. Md.</u>  |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer</u><br><u>434.4</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Suffer</u><br>DUE TO (c) <u>  </u>  |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u>  | 20d. INJURY OCCURRED<br>White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |   |   |   |
| ACTUAL SIGNATURE<br><u>E. Linhardt</u>   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><u>E. Linhardt</u>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   | DATE SIGNED<br><u>3/10/61</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 22b. DATE THEREOF<br><u>3-14-61</u>   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>U.S. National</u>  | 22d. LOCATION (City, town, or county) (State)<br><u>Annapolis, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>C.E. Hicks III - Annapolis, Maryland</u>  |   | 24a. REC'D BY REGISTRAR<br><u>MAR 21 '61</u>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>   |   |   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02619

2639

|   |                                     |   |   |   |   |   |  |
|---|-------------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                                     |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |   |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |                                     |   |   | c. LENGTH OF STAY IN lb<br><b>49 days</b>   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Plaza Manor Nursing Home</b>   |                                     |   |   | d. STREET ADDRESS<br><b>Rt. 1 Box 177 D</b>   |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Emma Johnson</b>  |                                     |   |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>9</b> Year <b>19 61</b>   |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 1, 1899</b>   | 9. AGE (In years last birthday)<br><b>71 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days                      | IF UNDER 24 HRS.<br>Hours Min.                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Sloatsburg, New York</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |                                     |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |                                     | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br><b>Alice Browne A.A. Co. D.P.W.</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>443X</b> IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) <b>443X</b> DUE TO<br>(e), stating the underlying cause last. |                                     |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>? yrs.</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |                                     |   |   |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br><b>19</b>  | Month, Day, Year<br><b>19 61</b>    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>Baltimore</b>   | (County)<br><b>Baltimore</b>                        | (State)<br><b>Md.</b>                             |  |
| 21. I certify that (I) (the hospital) attended the deceased from <b>January 19, 1961</b> to <b>March 9, 1961</b> that (I) (we) last saw the deceased alive on <b>March 4, 1961</b> and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above.  |                                     |   |   |   |   |   |  |
| 22a. SIGNATURE<br><b>James M. Pair</b>  |                                     | M.D.  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED<br><b>3-9-1961</b>   |   |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James M. Pair, M.D.</b>  |                                     | 22d. ADDRESS<br><b>400 N. Carrollton Avenue Balto. 23, Md.</b>  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B</b>   | 23b. DATE THEREOF<br><b>3-11-61</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chen Harsh</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>Chen Harsh, Md.</b>  |   |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. R. G. Funeral Home</b>  |                                     |   | ADDRESS<br><b>130 E. Pratt St.</b>  | 25a. REC'D BY REGISTRAR<br><b>DATE MAR 13 '61</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Huns</b> |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2640

02620

|  |  |                                |  |   |  |  |  |
|--|--|--------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH<br>e. COUNTY   |  |                                |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE   |  |  |  |
| Anne Arundel MARYLAND  |  |                                |  | Maryland Anne Arundel   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Annapolis  |  |                                |  | c. LENGTH OF STAY IN 1b<br>9 days   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Anne Arundel General Hospital  |  |                                |  | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>RURAL - Annapolis   |  |  |  |
|  |  |                                |  | d. STREET ADDRESS<br>Rt-2, Box-620A   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  |                                |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| Mary JOHNSON   |  |                                |  |   |  |  |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>Negro      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>January 2, 1902                                    |  |
|  |  |                                |  |   |  | 9. AGE (In years last birthday)<br>59 yrs.                             |  |
|  |  |                                |  |   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>House Wife  |  |                                |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
|  |  |                                |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland   |  |  |  |
| 13. FATHER'S NAME<br>Allen Champ   |  |                                |  | 14. MOTHER'S MAIDEN NAME<br>Attie Jones   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, No or unknown)  |  |                                |  | 16. SOCIAL SECURITY NO.<br>17. INFORMANT<br>Kranville Redding St Margaret Md  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 193.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO<br>(c) Glioma of left Parietal lobe of the Cerebrum<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br>10 days |  |                                |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                                |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                                |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour e.m.<br>p.m.   |  | Month, Day, Year<br>19         |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
|  |  |                                |  |   |  | 20f. (City or town) (County) (State)                                   |  |
| 21. I certify that (I) (the doctor) attended the deceased from Mar. 6, 1961 to Mar. 14, 1961 that (I) (we) saw the deceased alive on Mar. 14, 1961, and that death occurred at M, from the causes and on the date stated above.  |  |                                |  |   |  |  |  |
| 22a. SIGNATURE<br>R. L. Richardson   |  |                                |  | 22b. DATE<br>1:00 A.M.  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>R. L. Richardson   |  |                                |  | 22d. ADDRESS<br>110 Clay St., Annapolis, Md.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>3-18-1961 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Broadneck   |  | 23d. LOCATION (City, town or county) (State)<br>St Margaret Md         |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>William Reesett Anna Md  |  |                                |  | 25a. REC'D BY REGISTRAR<br>MAR 20 '61   |  |  |  |
|  |  |                                |  | 25b. REGISTRAR'S SIGNATURE<br>Arthur S. Kraus   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

08288

0130



7/1/50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02621

2641 Item 2c, Film G283 3/29/61

|   |                           |   |                                |
|---|---------------------------|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>AL</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u><br>c. LENGTH OF STAY IN <u>40 yrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u> |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD</u><br>b. COUNTY <u>Calvert</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golftown</u><br>d. STREET ADDRESS <u>04X-2</u> |                                |
| 3. NAME OF DECEASED<br>(Type or print) <u>Robert O. Johnson</u>   |                           | 4. DATE OF DEATH<br>Month <u>3</u> Day <u>17</u> Year <u>1961</u>   |                                |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>2-3-83</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |                                |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>   |                           | 12. CITIZEN OF WHAT COUNTRY?  |                                |
| 13. FATHER'S NAME <u>Elizah Johnson</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Minnie Keys</u>   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                           | 16. SOCIAL SECURITY NO.   |                                |
| 17. INFORMANT <u>Emma Harris, husband, MD</u>   |                           | Address   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>hypertensive pneumonia</u><br>DUE TO (b) <u>interior cardiac disease</u><br>DUE TO (c) <u>chronic brain syndrome</u>  |                           | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>  |                                |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |   |                                |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |                                |
| 20c. TIME OF INJURY<br>Hour <u>19</u> a.m. <u>19</u> p.m.   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3-3-61</u> to <u>3-17-61</u> , that (I) (we) last saw the deceased alive on <u>3-17-61</u> , and that death occurred at <u>19:00</u> from the causes and on the date stated above.   |                           |   |                                |
| 22a. SIGNATURE <u>Reginald R. Eismann</u> M.D.  |                           | 22b. DATE SIGNED <u>3/17/61</u>   |                                |
| 22c. PHYSICIAN'S NAME (Type) <u>HEARD-REISBMAN</u>  |                           | 22d. ADDRESS <u>CROWNSTOWN, MD</u>  |                                |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>3-21-61</u>   |                           | 23b. DATE THEREOF   |                                |
| 23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>   |                           | 23d. LOCATION (City, town or county) (State) <u>Lusby, Calvert MD</u>   |                                |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>  |                           | 25a. REC'D BY REGISTRAR <u>Mar 23 '61</u>   |                                |
| ADDRESS <u>P.O. Frederick, MD</u>   |                           | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>  |                                |

10585

1185



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2642

02622

|  |                              |   |  |  |   |   |                                     |
|--|------------------------------|---|--|--|---|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>AA</b> |   |   |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Gambrills</b>   |                              |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Gambrills</b>                             |   |   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Rte. 1, Box 600</b>   |                              |   |  | d. STREET ADDRESS<br><b>Rte. 1, Box 600</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Henry</b> Middle <b>A.</b> Last <b>Kaufmann</b>  |                              |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>19</b> Year <b>19 61</b>   |   |   |                                     |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 12, 1884</b> |  | 9. AGE (In years last birthday)<br><b>76</b> yrs. | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HRS.<br>Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Painter</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                     |
| 13. FATHER'S NAME<br><b>Adam Kaufmann</b>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Stupe</b>  |   |   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>220-05-7434</b>   |  | 17. INFORMANT Address<br><b>Mrs Katherine Kaufmann, same as 2</b>  |   |   |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure - Decomposat</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) <b>Sclerotic Cardiac Vascular Disease</b> (c) <b>Myocard</b> |                              |   |  |  |   |   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ca. Bladder metastases to lung. Histoplasmosis</b>  |                              |   |  |  |   |   |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |   |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 1961</b> to <b>March 19, 1961</b> , that (I) (we) lost saw the deceased alive on <b>March 11, 1961</b> , and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above.  |                              |   |  |  |   |   |                                     |
| 22a. SIGNATURE<br><b>Febus Grunberg, M.D.</b>  |                              |   |  | 22b. ADDRESS<br><b>Odenton, Md.</b>  |   |   |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>3/22/61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                            |                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping and Kirkley, Glen Burnie, Md</b>  |                              |   |  | 25a. REC'D BY REGISTRAR<br><b>MAR 21 '61</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>  |                                     |

88380

CERTIFICATE OF DEATH

88380



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2643

CERTIFICATE OF DEATH

Reg. Dist. No. 02623

|   |                                  |   |                                      |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Anne Arundel</i> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>                    |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Annapolis</i>  |                                  | c. LENGTH OF STAY IN 1b<br><i>X Churchton, Md.</i>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>Anne Arundel General</i>   |                                  | e. STREET ADDRESS<br><i>Franklin Manor</i>  |                                      |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><i>Clarence S. Keller</i>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><i>March 14 19 61</i>   |                                      |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>9/10/1874</i> |
| 9. AGE (In years last birthday)<br><i>86</i> yrs.   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>(ret'd) Musician</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><i>York, Pennsylvania</i>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S. A.</i>  |                                      |
| 13. FATHER'S NAME<br><i>Jacob F. Keller</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>Sarah E. Martin</i>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><i>578-10-8782</i>   |                                      |
| 17. INFORMANT<br><i>Gerald G. Keller, Franklin Manor, Churchton, Md</i>   |                                  | Address   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Bleeding esophageal varices</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cirrhosis of liver</i><br>DUE TO (c)                                   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><i>5 days</i><br><i>unknown</i>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. Month, Day, Year<br><i>19</i>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <i>Feb. 17, 1961</i> , to <i>March 14, 1961</i> , that I last saw the deceased alive on <i>March 14, 1961</i> , and that death occurred at <i>11:50 PM</i> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <i>Shady Side, Maryland</i><br>DATE SIGNED <i>3/15/61</i> |                                  |   |                                      |
| ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.   |                                  | PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, MD</i>   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |                                  | 22b. DATE THEREOF<br><i>3-17-61</i>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><i>Hampstead Cemetery</i>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><i>Hampstead, Md</i>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</i>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <i>MAR 20 '61</i>   |                                      |
| 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kline</i>  |                                  |   |                                      |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2644

CERTIFICATE OF DEATH

Reg. Dist. No.

62624

|  |                                  |  |                                      |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Anne Arundel</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>A. Arundel</b>                |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie Earleigh Hts.</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie Earleigh Hts.</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>P.O. box 54, Pasadena P.O., Md.</b>   |                                  | e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alfred</b> Middle <b>nevin</b> Last <b>Kelly Jr.</b>   |                                  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>30</b> Year <b>1961</b>  |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH<br><b>11-2-1925</b> |
| 9. AGE (In years last birthday) <b>35</b> yrs.   |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired)<br><b>foreman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>construction</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALT., MD.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                      |
| 13. FATHER'S NAME<br><b>ALFRED NEVIN SR (Dec)</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MRS ELIZ. BOSS (Dec)</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>218-18-8471</b>  |                                      |
| 17. INFORMANT<br><b>wife-Elizabeth Kelly-sane address.</b>   |                                  | Address  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarct-posterior wall.</b><br><b>420.1</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Previous infarct, same area.</b><br>DUE TO<br>(c) <b>7wks ago.</b>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Previously overweight, borderline hypertension.</b>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>No injury.</b>  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/> |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>-----</b>   |                                  | 20f. (City or town) (County) (State)<br><b>-----</b>   |                                      |
| 21. I certify that I attended the deceased from <b>9 Feb</b> , 19 <b>61</b> , to <b>30 March</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>29 March</b> , 19 <b>61</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>425 S. Ritchie Hwy.,</b> DATE SIGNED <b>30 March 1961</b><br>ACTUAL SIGNATURE <b>H.F. Manuzak</b> M.D. <b>Glen Burnie, Maryland.</b><br>PHYSICIAN'S NAME (Type) <b>H.F. Manuzak, M.D.</b> |                                  |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>3rd April '61</b>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Maryland</b>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>R. P. ...</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>APR 4 '61</b>   |                                      |
| ADDRESS<br><b>Glen Burnie, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>...</b>   |                                      |

CERTIFICATE OF DEATH

|                       |  |                           |  |                          |  |                              |  |
|-----------------------|--|---------------------------|--|--------------------------|--|------------------------------|--|
| Name of Deceased      |  | Sex                       |  | Age                      |  | Date of Birth                |  |
| John Doe              |  | Male                      |  | 35                       |  | 1-1-1900                     |  |
| Place of Birth        |  | Cause of Death            |  | Date of Death            |  | Time of Death                |  |
| New York City         |  | Heart Disease             |  | 1-15-1935                |  | 10:00 AM                     |  |
| Usual Residence       |  | Occupation                |  | Physician                |  | Hospital                     |  |
| 123 Main St.          |  | Teacher                   |  | Dr. Smith                |  | St. Mary's                   |  |
| Manner of Death       |  | Place of Death            |  | Signature of Physician   |  | Signature of Registrar       |  |
| Natural               |  | Home                      |  | [Signature]              |  | [Signature]                  |  |
| Disease or Injury     |  | Anatomical Description    |  | Medical History          |  | Remarks                      |  |
| Myocardial Infarction |  | Heart enlarged, congested |  | No previous illness      |  | No autopsy                   |  |
| Cause of Death        |  | Immediate Cause           |  | Underlying Cause         |  | Contributing Cause           |  |
| Coronary Thrombosis   |  | Myocardial Infarction     |  | Hypertension             |  | Atherosclerosis              |  |
| Period of Incubation  |  | Duration of Illness       |  | Time from Onset to Death |  | Time from Admission to Death |  |
| None                  |  | 10 days                   |  | 24 hours                 |  | 3 days                       |  |
| Date of Report        |  | Signature of Reporter     |  | Signature of Physician   |  | Signature of Registrar       |  |
| 1-16-1935             |  | [Signature]               |  | [Signature]              |  | [Signature]                  |  |

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

62625

|   |                               |  |                                    |
|---|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A.A. Co</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co</u>               |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>   |                               | c. LENGTH OF STAY IN 1b <u>24 YRS</u>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEDOVA Rd &amp; VIENNING AVE</u>  |                               | d. STREET ADDRESS <u>MEDOVA Rd &amp; VIENNING AVE</u>  |                                    |
| 3. NAME OF DECEASED (Type or print) <u>Emma</u> First <u>M. MILLER</u> Middle <u>KEYSER</u> Last  |                               | 4. DATE OF DEATH <u>MARCH</u> Month <u>15</u> Day <u>19</u> Year <u>61</u>   |                                    |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3 JAN 1894</u> |
| 9. AGE (In years, last birthday) <u>67</u> yrs.   |                               | IF UNDER 1 YEAR: Months <u>6</u> Days <u>7</u> Hours <u>15</u> Min. <u>00</u>  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GLASS Co</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>GLASS Co</u>  |                                    |
| 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                    |
| 13. FATHER'S NAME <u>MILLER</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>JULIA NEIDEMEYER</u>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                               | 16. SOCIAL SECURITY NO. <u>19-00-6658</u>  |                                    |
| 17. INFORMANT <u>WILBUR KEYSER</u> Address <u>7011 MAISEL St</u>  |                               |  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>151X Adenocarcinoma of stomach</u><br>DUE TO (b) <u>6 months</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) <u>Diabetes mellitus</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> |                               |  |                                    |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I attended the deceased from <u>12/20, 1960, to 3/14, 1961</u> , that I last saw the deceased alive on <u>3/14, 1961</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>529 Camp Meade Rd. Linthicum, Md.</u> DATE SIGNED  |                               |  |                                    |
| ACTUAL SIGNATURE <u>Bahram Sina</u>   |                               | M.D. <u>529 Camp Meade Rd. Linthicum, Md.</u>  |                                    |
| PHYSICIAN'S NAME (Type) <u>BAHRAM SINA</u>  |                               |  |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 22b. DATE THEREOF <u>17 March 1961</u>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY <u>BALTO National</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>BALTO Md</u>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Paulson</u> ADDRESS <u>7309 WASH BLVD</u>  |                               | 24a. REC'D BY REGISTRAR DATE <u>MAR 17 '61</u>   |                                    |
|   |                               | 24b. REGISTRAR'S SIGNATURE <u>Christina S. Kline</u>   |                                    |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## 2646

02626

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|--|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>AA</u> <u>MARYLAND</u>   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Green Anne</u>               |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Crownsville</u>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>  |                                    |
| c. LENGTH OF STAY in lb<br><u>7/3/61</u>   |                              | d. STREET ADDRESS<br><u>1706 Linden Avenue</u>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Crownsville State Hospital</u>  |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Julia</u>   |                              | 4. DATE OF DEATH<br>Month <u>3</u> Day <u>5</u> Year <u>1961</u>  |                                    |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>2-16-81</u> |
| 9. AGE (In years last birthday)<br><u>80</u> yrs.  |                              | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>UNKNOWN</u>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>   |                                    |
| 13. FATHER'S NAME<br><u>UNKNOWN</u>  |                              | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>UNKNOWN</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>don't know</u>  |                                    |
| 17. INFORMANT<br><u>Medical Record</u>   |                              | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute heart failure assoc. senility</u><br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>CBS assoc. &amp; Arteriosclerotic CVD</u><br>(c) <u>UNKNOWN</u><br>DUE TO<br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>80 yrs.</u><br><u>UNKNOWN</u> |                              |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. <u>19</u>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/3/</u> 19 <u>61</u> to <u>3/5/</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3/5/</u> 19 <u>61</u> , and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above.   |                              |   |                                    |
| 22a. SIGNATURE<br><u>L. BENEDICT MD</u>  |                              | 22b. DATE SIGNED<br><u>3/5/61</u>   |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><u>L. BENEDICT MD</u>  |                              | 22d. ADDRESS<br><u>CROWNSSVILLE STATE HOSPITAL</u>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 23b. DATE THEREOF<br><u>3/9/61</u>  |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Chesterfield Cem.</u>   |                              | 23d. LOCATION (City, town or county) (State)<br><u>Centreville, Maryland</u>  |                                    |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Benneth W. Waley</u>  |                              | 25a. REC'D BY REGISTRAR<br><u>DATE MAR 8 '61</u>  |                                    |
| ADDRESS<br><u>Centreville, MD</u>  |                              | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Thomas</u>   |                                    |

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11.11.

London

Dear Sir,  
I have the pleasure to acknowledge the receipt of your letter of the 11th inst. in relation to the above matter.

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Yours faithfully,  
[Signature]

Director, [Organization]

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2647

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

02627

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brooklyn Park</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>X</b> <b>Brooklyn Park</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>131 Meadow Road</b>  |  |   |  | d. STREET ADDRESS<br><b>131 Meadow Road</b>   |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Fleming</b> Middle <b>H.</b> Last <b>Knowles</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>17</b> Year <b>1961</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 1, 1904</b>                      |  |
| 9. AGE (In years lost birthday)<br><b>56</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Service Man</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Outdoor Advertising Balto. Md.</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U. S.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Clarence C. Knowles</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Pauline Beck</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>216-10-0476</b>   |  | 17. INFORMANT<br><b>Mrs. Emma Knowles</b> Address <b>Same</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>442X</b> IMMEDIATE CAUSE (a) <b>coronary occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>hypertensive cardiovascular disease</b><br>DUE TO<br>(c) <b>1 yr.</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10/25</b> 19 <b>54</b> to <b>3/17</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3/17</b> 19 <b>61</b> , and that death occurred at <b>3 A.</b> M., from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Philip W. Keister, M.D.</b>  |  |   |  | 22b. DATE SIGNED<br><b>3/17/61</b>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Philip W. Keister</b>  |  |   |  | 22d. ADDRESS<br><b>301 Patapsco Ave Balto 25</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   |  | 23b. DATE THEREOF<br><b>March 20, 1961</b>  |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  |   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Mitchie Hwy. A. A. Co., Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>George J. Gonce</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>4001 Mitchie Hwy.</b>   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>George J. Gonce</b>  |  |   |  | 25c. DATE<br><b>MAR 22 '61</b>  |  |   |  |

03330

CERTIFICATE OF DEATH

3033

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|------------------|--|-----------------------|--|
| Name of Deceased |  | Date of Birth         |  |
| John Doe         |  | 1900-01-01            |  |
| Sex              |  | Age                   |  |
| Male             |  | 25                    |  |
| Race             |  | Occupation            |  |
| White            |  | Farmer                |  |
| Marital Status   |  | Cause of Death        |  |
| Married          |  | Heart Disease         |  |
| Date of Death    |  | Place of Death        |  |
| 1925-06-15       |  | Home                  |  |
| Time of Death    |  | Physician's Signature |  |
| 10:00 AM         |  | J. H. Smith, M.D.     |  |
| Burial Place     |  | Burial Date           |  |
| Cemetery         |  | 1925-06-18            |  |
| Burial Time      |  | Burial Place          |  |
| 11:00 AM         |  | Cemetery              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2648

## CERTIFICATE OF DEATH

02628

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND   |  |                             |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>A.A.Co.</u>                    |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>   |  |                             |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis 10</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>119 CHARLES ST.</u>   |  |                             |  | d. STREET ADDRESS <u>119 CHARLES ST. 1</u>   |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                             |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>EDITH CHILDS KOOLAGE</u>  |  |                             |  | 4. DATE OF DEATH Month Day Year<br><u>3 20 1961</u>  |  |   |  |
| 5. SEX <u>F</u>   |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>9-3-1889</u>                          |  |
| 9. AGE (In years last birthday) <u>71</u> yrs.  |  | IF UNDER 1 YEAR Months Days |  | IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PUBLIC SCHOOL</u>  |  |                             |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>TEACHER</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |                             |  |  |  |   |  |
| 13. FATHER'S NAME <u>William F. Childs Sr.</u>  |  |                             |  | 14. MOTHER'S MAIDEN NAME <u>MARY BOSWELL</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |                             |  | 16. SOCIAL SECURITY NO.  |  |   |  |
| 17. INFORMANT Address <u>MRS. FRANK M. CORNER #2</u>  |  |                             |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cerebral metastasis of carcinoma</u><br>DUE TO <u>160.0</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>epidermoid carcinoma of nose</u><br>DUE TO <u>3 1/2 yrs.</u><br>(c) <u>X-ray therapy to face for acne</u><br>DUE TO <u>50 yrs.</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                             |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |                             |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>11-30 1960</u>  |  |                             |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                             |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-30 1960</u> to <u>3-20 1961</u> , that (I) (we) last saw the deceased alive on <u>3-19 1961</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.   |  |                             |  |  |  |   |  |
| 22a. SIGNATURE <u>Barber C. Palmer Jr.</u> M.D.   |  |                             |  | 22b. DATE SIGNED <u>3-21-61</u>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>BARBER C. PALMER JR.</u>  |  |                             |  | 22d. ADDRESS <u>77 FRANKLIN ST. ANNAPOLIS, MD.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF           |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City, town, or county) (State)             |  |
| <u>BURIAL</u>   |  | <u>3-22-61</u>              |  | <u>CEDAR BLUFF</u>   |  | <u>Annapolis MD.</u>                                      |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lortz &amp; Sons Annapolis, Md.</u>   |  |                             |  | 25a. REC'D BY REGISTRAR DATE <u>MAR 22 '61</u>   |  |   |  |
|   |  |                             |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |  |   |  |

03028

CERTIFICATE OF DEATH

03028

(M)

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Registrar" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2649  
CERTIFICATE OF DEATH  
02629

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b><br>c. LENGTH OF STAY IN 1b<br><b>10</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Anne Arundel General Hospital</b> |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b><br>d. STREET ADDRESS<br><b>31 A Murray Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Edward F. LEONARD</b>  |                                  | 4. DATE OF DEATH<br>Month<br><b>March</b><br>Day<br><b>27</b><br>Year<br><b>1961</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>September 22, 1907</b> |
| 9. AGE (In years last birthday)<br><b>53 yrs.</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months<br><b>5</b><br>Days<br><b>3</b><br>Hours<br><b>1</b><br>Min.<br><b>1</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Pres Leonard Sons Importing Goods Co. Annapolis</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   |
| 13. FATHER'S NAME<br><b>Charles Leonard</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Louise Bondoy</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>(Yes, no, or unknown)</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>Laurel D. Leonard</b>  |   |
| 17. INFORMANT<br><b>Laurel D. Leonard</b>   |                                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral Arteriosclerosis</b><br>(c) <b>Arteriosclerosis Generalized</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerosis Generalized</b> |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hrs</b><br><b>1 hr</b><br><b>1 hr</b>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) <b>(XX hospital)</b> attended the deceased from <b>Dec. 1, 1959</b> to <b>Mar. 27, 1961</b> , that (I) <b>(XX)</b> last saw the deceased alive on <b>Mar. 27, 1961</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.                                     |                                  |  |   |
| 22a. SIGNATURE<br><b>James R. Martin</b><br>M.D.  |                                  | 22b. DATE SIGNED<br><b>3-29-61</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James R. Martin</b>  |                                  | 22d. ADDRESS<br><b>6 Shaw St., Annapolis, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Buried</b>  |                                  | 23b. DATE THEREOF<br><b>3-30-1961</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Memorial</b>   |                                  | 23d. LOCATION (City, town or county) (State)<br><b>Annapolis</b><br><b>MD</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor Sons</b>  |                                  | 25. REC'D BY REGISTRAR<br>DATE<br><b>MAR 30 '61</b>  |   |
| 26. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>   |                                  |  |   |

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]*

1  
FOR STATE  
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

VS. A15ME  
5M 7/59

2630  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE-1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02630

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>                   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dorsey</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harwood Park</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Baltimore-Washington Expressway</b>  |  |  |  | d. STREET ADDRESS <b>7119 Athol Avenue</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HENRY</b> Middle <b>JOHN</b> Last <b>LEWIS</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>5</b> Year <b>1961</b>  |  |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>3/23/97</b>                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Disabled Veteran for 27 years</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 9. AGE (In years last birthday) <b>63</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>13</b> Days <b>X-2</b> |  |
| 11. BIRTHPLACE (State or foreign country) <b>Huntington, N. Y.</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |   |  |
| 13. FATHER'S NAME <b>Henry J. Lewis</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Greeley</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>First World War</b>  |  |  |  | 16. SOCIAL SECURITY NO. <b>?</b>  |  | 17. INFORMANT <b>Mrs. Helen Lewis (wife)</b>        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>422.1</b><br>(c), stating the underlying cause last. DUE TO (c)   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>e.m.</b> p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Russell S. Fisher</b>  |  |  |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>  |  |  |  | DATE SIGNED <b>3/6/61</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>3/9/1961</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem. Baltimore Maryland</b>  |  | 22d. LOCATION (City, town, or country) (State)      |  |
| 23. FUNERAL DIRECTOR <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Ave.</b>   |  |  |  | 24a. REC'D BY REGISTRAR <b>MAR 8 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02631

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>  |  | c. LENGTH OF STAY IN 1b<br><b>13 YRS.</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>USNH ANNAPOLIS, MD.</b>  |  |   |  | d. STREET ADDRESS<br><b>18 N. GLEN AVE.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EDITH</b> Middle <b>HILL</b> Last <b>MATTIE</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>11</b> Year <b>19 61</b>  |  |   |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>CAU</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-15-05</b>  |  |
| 9. AGE (In years last birthday)<br><b>55 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOMEMAKER</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>- - -</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Mass.</b>                               |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>JAMES DICKEY HILL</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH BURROWS</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>- - -</b>   |  | 17. INFORMANT<br><b>USNH ANNAPOLIS, MARYLAND</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MULTIPLE ABDOMINAL ABSCESSSES</b><br>DUE TO <b>153-8</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA OF COLON</b><br>DUE TO (c) |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 DAYS</b><br><b>1 1/2 YRS</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3-11</b> , 19 <b>61</b> to <b>3-11</b> , 19 <b>61</b> , that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <b>3-10</b> , 19 <b>61</b> , and that death occurred at <b>1230PM</b> from the causes and on the date stated above.                      |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><i>Sydney Busch</i>   |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>3-11-61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>S. (N) BUSCH LT MC USNR</b>  |  |   |  | 22d. ADDRESS<br><b>USNH ANNAPOLIS, MD.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Mar 14-1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Naval Academy Cent</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Annapolis Md.</b>                              |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>John M. Taylor Sons</i>  |  |   |  | ADDRESS<br><b>Annapolis Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DATE MAR 14 '61</b>   |  |
|   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Haus</i>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2652

02532

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A. A. Co.</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>              |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>127 Club Road</u>  |                               | d. STREET ADDRESS <u>127 Club Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>                               |                                       |
| 3. NAME OF DECEASED (Type or print) First <u>W.</u> Middle <u>Harold</u> Last <u>Miles</u>   |                               | 4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1961</u>  |                                       |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 30, 1887</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs.   |                               | IF UNDER 1 YEAR Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerk-Supreme Court</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md.</u>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                       |
| 13. FATHER'S NAME <u>S. Milton Miles</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Clara Bodensick</u>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <u></u>  |                                       |
| 17. INFORMANT <u>Mrs. Miriam Eslinger-1649 Waverly Way</u>   |                               | Address <u></u>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO <u>Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.<br>(b) <u></u><br>(c) <u></u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>30 mins.</u><br><u>5 years</u>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>July 15, 1961</u> to <u>Mar. 7, 1961</u> , that (I) ( <u>was</u> ) last saw the deceased alive on <u>Mar. 5, 1961</u> and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.   |                               |  |                                       |
| 22a. SIGNATURE <u>R. M. McLaughlin</u>   |                               | 22b. DATE SIGNED <u>Mar. 7, 1961</u>   |                                       |
| 22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>   |                               | 22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE THEREOF <u>3-11-61</u>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>  |                               | 23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>   |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tucker &amp; Sons</u>  |                               | 25a. REC'D BY REGISTRAR <u>Mar 9 '61</u>   |                                       |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Pina</u>   |                               |  |                                       |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 2 and 3 should be filed with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit.

VR A15 (4)  
15M 9/59

3653

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2653

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <i>a a.</i> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>md.</i> b. COUNTY <i>A A</i>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>  |                               | c. LENGTH OF STAY IN 1b  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>12 Church Circle</i>   |                               | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>   |   |
| d. STREET ADDRESS <i>1317 N. Glen Ave</i>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <i>Morris Milton Moesch</i>  |                               | 4. DATE OF DEATH Month <i>3</i> - Day <i>23</i> Year <i>1961</i>   |   |
| 5. SEX <i>Male</i>   | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Apr. 29<sup>th</sup> 1888</i> |
| 9. AGE (In years lost birthday) <i>72</i> yrs.   |                               | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret Ordnance &amp; Ammunition</i>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Academy</i>  |   |
| 11. BIRTHPLACE (State or foreign country) <i>Ill.</i>  |                               | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |   |
| 13. FATHER'S NAME <i>Charles Moesch</i>  |                               | 14. MOTHER'S MAIDEN NAME <i>Ellen Amelia Siepied</i>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <i>Priscilla Cecelia Moesch</i>  |                               | Address <i>(2)</i>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Coronary Thrombosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis - Heart Disease</i> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Asthma, Bronchitis</i> |                               | INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <i>3-23-1961</i> to <i>3-23-1961</i> , that (I) (we) lost the deceased alive on <i>3-23-1961</i> , and that death occurred at <i>Md.</i> from the causes and on the date stated above.   |                               |  |   |
| 22a. SIGNATURE <i>James R. Martin</i>  |                               | 22b. DATE SIGNED <i>3-24-61</i>  |   |
| 22c. PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>  |                               | 22d. ADDRESS <i>6 SHAW ST. ANNAPOLIS, MD.</i>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  |                               | 23b. DATE THEREOF <i>3-26-1961</i>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Neelcrest Memorial</i>   |                               | 23d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>  |                               | 25a. REC'D BY REGISTRAR <i>MAR 27 '61</i>  |   |
| ADDRESS <i>Annapolis Md</i>  |                               | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>  |   |

CERTIFICATE OF DEATH

2023

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*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words are difficult to decipher but appear to include:]*

*... of ...*  
*... at ...*  
*... on ...*  
*... by ...*  
*... cause ...*  
*... manner ...*  
*... place ...*  
*... time ...*  
*... age ...*  
*... sex ...*  
*... race ...*  
*... occupation ...*  
*... service ...*  
*... rank ...*  
*... name ...*  
*... signature ...*  
*... date ...*

FOR STATE  
HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02634

|   |                              |   |                      |   |                 |   |       |
|---|------------------------------|---|----------------------|---|-----------------|---|-------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>A.A. CO</u>   |                              |   |                      | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>A.A. CO.</u> |                 |   |       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Annapolis</u>  |                              |   |                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Dividing Creek Rd.</u>                         |                 |   |       |
| c. LENGTH OF STAY IN 1b   |                              |   |                      | d. STREET ADDRESS<br><u>ARNOLD - MD</u>   |                 |   |       |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>D.O.A. ANNE ARUNDEL - General</u>  |                              |   |                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |                 |   |       |
| 3. NAME OF DECEASED<br>(Type or print)  |                              | First   |                      | Middle  |                 | Last  |       |
|   |                              | <u>William</u>  |                      |   |                 | <u>MOO9</u>   |       |
| 4. DATE OF DEATH  |                              | Month   |                      | Day   |                 | Year  |       |
|   |                              | <u>3</u>  |                      | <u>20</u>   |                 | <u>1961</u>   |       |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                     | 8. DATE OF BIRTH     | 9. AGE (In years last birthday)   | IF UNDER 1 YEAR | IF UNDER 24 HRS.  |       |
|   |                              | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | <u>5th Feb. 1922</u> | <u>61</u> yrs.  | Months          | Days  | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Ch. War. Off. (U.S.C. 6) Ret.</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |                      | 11. BIRTHPLACE (State or foreign country)<br><u>Baltoy Md.</u>  |                 | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                       |       |
| 13. FATHER'S NAME<br><u>William H. MOO9</u>   |                              |   |                      | 14. MOTHER'S MAIDEN NAME<br><u>Lottie Stoker</u>  |                 |   |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>Yes</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>None</u>  |                      | 17. INFORMANT<br><u>Mrs. Margaret A. MOO9</u>   |                 | Address<br><u>Same As #2</u>  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |                      |   |                 |   |       |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u><br><u>420.1</u><br>DUE TO<br>(b) <u>Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)   |                              | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>   |                      |   |                 |   |       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              |   |                      |   |                 |   |       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)               |                      |   |                 |   |       |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                 | 20f. (City or town) (County) (State)                                |       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |                      |   |                 |   |       |
| ACTUAL SIGNATURE<br><u>E. L. M. H. H. H.</u>  |                              | M.D.  |                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                 | DATE SIGNED<br><u>3/20/61</u>                                       |       |
| EXAMINER'S NAME (Type)<br><u>E. L. M. H. H. H.</u>  |                              | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                      | Address (Street, city, town, or county)   |                 |   |       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 22b. DATE THEREOF<br><u>24th March '61</u>  |                      | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Balto. Nat'l. Cem.</u>   |                 | 22d. LOCATION (City, town, or country) (State)<br><u>Baltoy Md.</u> |       |
| 23. FUNERAL DIRECTOR<br><u>R. V. Singleton</u>  |                              | ADDRESS<br><u>Glen Burnie Md.</u>   |                      | 24a. REC'D BY REGISTRAR<br>DATE<br><u>MAR 23 '61</u>  |                 | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. H. H.</u>                |       |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2655

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02635

|  |                               |  |                                     |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>AA</i> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Md.</i> b. COUNTY <i>AA</i>                         |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Igleharts</i>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Igleharts</i>  |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ROUTE 178</i>  |                               | d. STREET ADDRESS <i>ROUTE 178</i>   |                                     |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                     |
| 3. NAME OF DECEASED (Type or print) First <i>Nora</i> Middle <i>Moran</i> Last <i>Moran</i>  |                               | 4. DATE OF DEATH Month <i>3</i> Day <i>18</i> Year <i>1961</i>   |                                     |
| 5. SEX <i>Female</i>   | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Nov 22 1884</i> |
| 9. AGE (In years last birthday) <i>76</i> yrs.   |                               | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>  |                                     |
| 11. BIRTHPLACE (State or foreign country) <i>Cambridge Md</i>  |                               | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>   |                                     |
| 13. FATHER'S NAME <i>James Calloway</i>  |                               | 14. MOTHER'S MAIDEN NAME <i>Sarah Whaley</i>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>   |                               | 16. SOCIAL SECURITY NO. <i>-</i>   |                                     |
| 17. INFORMANT <i>Ms. John Moran #2</i>   |                               | Address <i>#2</i>  |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i><br>416X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic Heart Disease</i><br>DUE TO<br>(c) <i>Unknown probably a few minutes</i> |                               |  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <i>June 1960</i> to <i>March 18 1961</i> , that (I) <del>was</del> last saw the deceased alive on <i>Jan 1961</i> , and that death occurred at <i>1234 PM</i> , from the causes and on the date stated above.  |                               |  |                                     |
| 22a. SIGNATURE <i>Mr. T. Stephens</i>  |                               | 22b. DATE SIGNED   |                                     |
| 22c. PHYSICIAN'S NAME (Type)   |                               | 22d. ADDRESS <i>38 Carroll Commack Rd</i>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                               | 23b. DATE THEREOF  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY   |                               | 23d. LOCATION (City, town, or county) (State)  |                                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE   |                               | 25a. REC'D BY REGISTRAR  |                                     |
| 25b. REGISTRAR'S SIGNATURE   |                               | DATE   |                                     |

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CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |
| 2656 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02636   |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b>   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Same</b><br>b. COUNTY <b>Same</b>                                 |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 25</b>   |  |  |  |  | c. LENGTH OF STAY IN 1b <b>Few minutes</b>   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>229 Berlin Ave. Potapsco Park</b>  |  |  |  |  | d. STREET ADDRESS <b>Same</b>  |  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Norman Muldrow</b>  |  |  |  |  | 4. DATE OF DEATH <b>March 29th. 19 61</b>  |  |  |  |  |
| 5. SEX <b>M</b>  |  |  |  |  | 6. COLOR OR RACE <b>C</b>  |  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 8. DATE OF BIRTH <b>9/10/96</b>  |  |  |  |  |
| 9. AGE (In years last birthday) <b>64</b> yrs.   |  |  |  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>Darlington.S.C.</b>   |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  |  |
| 13. FATHER'S NAME <b>Irvin Muldrow</b>   |  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Emma Lunn</b>  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes, World War No 1</b>  |  |  |  |  | 16. SOCIAL SECURITY NO. <b>218-10-3013</b>   |  |  |  |  |
| 17. INFORMANT <b>Mrs.Philip Marner (Oldest daughter)</b>   |  |  |  |  | Address  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Self strangulation with a clothes line.</b><br>974X<br>Conditions, if any, which gave rise to immediate cause (b) <b>Few minutes</b><br>(a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Placed a clothes line around his neck that he fastened to a rafter</b> |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>4 p.m. 3/29/61 19</b>  |  |  |  |  | 20d. INJURY OCCURRED <b>Home</b><br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>                                       |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baltimore 25, A.A. Md.</b>   |  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Gustave H. Faubert</b>   |  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>   |  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |  | 3/29/61 DATE SIGNED  |  |  |  |  |
| Address (Street, city, town, or county) <b>Glen Burnie, Md.</b>  |  |  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  |  |  | 22b. DATE THEREOF <b>9/3/1961</b>  |  |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>St. Schrodner St.</b>  |  |  |  |  | 22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>  |  |  |  |  |
| 23. FUNERAL DIRECTOR <b>Mrs. Katie R. Williams</b>   |  |  |  |  | 24a. REC'D BY REGISTRAR <b>APR 4 '61</b>   |  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>   |  |  |  |  |  |  |  |  |  |

04538

04538

(M)

name: [illegible]

Birthplace: [illegible]

100 Berlin Ave. [illegible]

March 1935 [illegible]

[illegible]

Self employed. [illegible]

[illegible]

Yes. World War I [illegible]

Self strangulation with a clothes line. [illegible]

X

[illegible]

[illegible]

3/25/02

X

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2657

## CERTIFICATE OF DEATH

Reg. Dist. No. 02637

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE <b>MARYLAND</b> c. COUNTY <b>ANNE ARUNDEL</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ANNAPOLIS</b>   |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SEVERNA PARK</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>S. NAVAL HOSPITAL, ANNAPOLIS, MD.</b>   |                                     | d. STREET ADDRESS<br><b>MANHATTEN MANOR</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>PAUL</b> First <b>NORMAN</b> Middle <b>MYATT</b> Last  |                                     | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>10</b> Year <b>19 61</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>CAUC.</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>18 MAY 1912</b>                               |
| 9. AGE (In years last birthday) yrs. <b>48</b>   |                                     | 10. IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ENLISTED USN</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MASSACHUSETTS</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>  |  |
| 13. FATHER'S NAME<br><b>Joseph MYATT</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Annie BEACON</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW II</b>   |                                     | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>(Wife) Frances MYATT, SEVERNA PARK, MARYLAND</b>   |                                     | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary edema</b><br>DUE TO <b>SOIX</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic tracheo bronchitis</b><br>DUE TO <b>aspiration</b><br>(c) <b>aspiration</b> |                                     |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>INTESTINAL OBSTRUCTION - CA STOMACH</b>  |                                     |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>8 February</b> , 1961, to <b>10 March</b> , 1961, that I last saw the deceased alive on <b>10 March</b> , 1961, and that death occurred at <b>3:04 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>10 March 1961</b>                                   |                                     |   |  |
| ACTUAL SIGNATURE <b>Stephen B. Hiltabiddle</b> M.D.  |                                     | 10 March 1961   |  |
| PHYSICIAN'S NAME (Type) <b>Stephen B. HILTABIDDLE, LT MC USNR, U. S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</b>   |                                     |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>3/14/61</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>ARLINGTON VA</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>NONN M. TAYLOR, Son ANNAPOLIS MD.</b>   |                                     | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 14 '61</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                     |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 3. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2658 CERTIFICATE OF DEATH 02638

|  |                              |   |  |  |   |
|--|------------------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELNORA PARKER</b>  |                              |   | 2. DATE OF DEATH<br><b>March 26, 1961</b>  |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>4109 Bellgrove Rd<br/>Baltimore 25, Md.</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |                              |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>QUEEN ANNE</b><br>C. CITY OR TOWN <b>WYE MILLS RURAL</b> (If outside city limits, write RURAL and give township)<br>D. STREET ADDRESS <b>RT. 50 -</b> (If rural, give location) |  |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b> | 8. DATE OF BIRTH<br><b>3/9/1901</b>  | 9. AGE (In years last birthday)<br><b>60</b> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>—</b>  |                              |   | 11. BIRTHPLACE (State or foreign country)<br><b>NORTH CAROLINA</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>             |
| 13. FATHER'S NAME<br><b>JOHN G BEASLEY</b>   |                              |   | 14. MOTHER'S MAIDEN NAME<br><b>YOUNG OR HAWKIN</b>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>—</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>—</b>                               | 17. INFORMANT ADDRESS<br><b>MR. PARKER - WYE MILLS - MD.</b>   |  |   |

|   |   |  |   |
|---|---|--|---|
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>I Adenocarcinoma of S. J. last 6 months</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>191X Generalized metastases</b><br><b>Diabetes mellitus</b> | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |
|   | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |   |
|   |   |  |   |

|  |  |   |   |
|--|--|---|---|
| IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PAR. II   | 19A. DATE OF OPERATION<br><b>February 10</b>                 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>1961</b>                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 22. I certify that (I) (this hospital) attended the deceased from <b>February 10</b> <b>1961</b> to <b>March 26</b> <b>1961</b> that (I) (we) last saw the deceased alive on <b>March 26</b> <b>1961</b> and that in (my) (our) opinion death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above. |  |   |   |
| 23A. SIGNATURE<br><b>Robert Dabolin</b><br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   | 23B. ADDRESS<br><b>642 Washington Blw. #30, N. Baltimore</b> |   |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 24B. DATE<br><b>3/29/61</b>                                  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>YOUNG CEMETERY</b>                                   | 24D. LOCATION (City, town, or county) (State)<br><b>BENSON - NORTH CAROLINA</b>     |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>MAR 27 '61</b>   | 25B. NAME OF REGISTRAR<br><b>Arthur S. Hines</b>             | 25C. FUNERAL DIRECTOR<br><b>JAMES G. SAFFELL JR</b><br>ADDRESS<br><b>WESTMINSTER MARYLAND</b> |   |

25050

955



05030

05030

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1

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "the", "to the", and "from" are faintly visible.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **02640**

**2660**

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Lothian</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Lothian Maryland</b> b. COUNTY <b>Anne Arundel</b>     |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lothian</b>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Rural</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>McKendree Road</b>  |  |   |  | d. STREET ADDRESS<br><b>McKendree Road</b>  |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alexander</b> Middle <b>Powell</b> Last <b>Powell</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>19</b> Year <b>1961</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>C</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1-20-1896</b>                                      |  |
| 9. AGE (In years last birthday)<br><b>65</b>   |  | IF UNDER 1 YEAR<br>Months <b>65</b>   |  | IF UNDER 24 HRS.<br>Days <b>65</b> Hours <b>65</b> Min. <b>65</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>General Laborer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>*****</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Anne Arundel Co. Md.</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT Address<br><b>Gladys Stergiou- 27 Larkins St. Anna. Md.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Shot gun wound right side of neck ( suicide)</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>976X</b><br>DUE TO (c) |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b>9:40</b> a. m. <b>p. m.</b> Month <b>3/19</b> Day <b>1961</b>   |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Lothian</b>  |  | 20f. (City or town) (County) (State)<br><b>AA Md</b>                      |  |
| 21. I certify that I attended the deceased from <b>not at all</b> 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Emily H. Wilson</b> M.D.   |  |   |  | PHYSICIAN'S NAME (Type) <b>Emily H. Wilson M.D. Deputy Coroner - Lothian Maryland</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>3-23-61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Moses</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Drury - Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.E.HICKS 111 Annapolis, Maryland</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 23 '61</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**FOR STATE HEALTH DEPT.**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**2661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**02641**

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> |  |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Shadyside</b>  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>A.A. General Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Maurice B. POWELL, JR.</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>22</b> Year <b>1961</b>   |  |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                         | 8. DATE OF BIRTH<br><b>9-19-1957</b>                                   | 9. AGE (In years last birthday)<br><b>3</b> yrs.  | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>3</b> | IF UNDER 24 HRS.<br>Hours <b>3</b> Min. <b>3</b> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>    |   |
| 13. FATHER'S NAME<br><b>Maurice B. Powell</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Fannie White</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |  | 17. INFORMANT<br><b>Maurice B. Powell</b> Address <b>Shadyside</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Severe brain swelling following cardiac arrest during circumcision.</b><br>945X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c) DUE TO<br>(a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Severe brain swelling following cardiac arrest during circumcision</b> |  |   |  |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>10:30</b> p.m. <b>3/20/61</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Hospital</b>  | 20f. (City or town) (County) (State)<br><b>Anne Arundel Md.</b>        |   |  |  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |   |  |  |   |
| ACTUAL SIGNATURE<br><b>William V. Lovitt, Jr., M.D.</b>   |  | M.D.   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | DATE SIGNED<br><b>March 23, 1961</b>             |   |
| EXAMINER'S NAME (Type)<br><b>William V. Lovitt, Jr., M.D.</b>   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  | Address (Street, city, town, or county)<br><b>Shadyside Md.</b>   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>3-25-1961</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mathew's</b>  | 22d. LOCATION (City, town, or country) (State)<br><b>Shadyside Md.</b> |   |  |  |   |
| 23. FUNERAL DIRECTOR<br><b>William Reese II</b>   |  |  | ADDRESS<br><b>Annapolis, Md.</b>                                       |   | 24a. REC'D BY REGISTRAR<br><b>MAR 24 '61</b>     |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |

TO DISTRIBUTE: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

0504

0504



James Arundel

James Arundel

March 22, 1901

March 22, 1901

March 22, 1901

March 22, 1901



March 22, 1901

March 22, 1901

March 22, 1901

March 22, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper's. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

| <div>1</div> <div>2662</div> <div>02642</div>   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| <div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>Anne Arundel</div> <div>MARYLAND</div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Laurel</div> <div>c. LENGTH OF STAY IN 1b</div> <div>14 months</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>District Training School, Children's Center</div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>b. COUNTY</div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Washington, D.C.</div> <div>d. STREET ADDRESS</div> <div>426 - 6th St. N.E., Apt. 104</div> <div>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div>3. NAME OF DECEASED (Type or print)</div> <div>First Middle Last</div> <div>David Roesha Pugh</div> <div>4. DATE OF DEATH</div> <div>Month Day Year</div> <div>March 7, 19 61</div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div>5. SEX</div> <div>Male</div> <div>6. COLOR OR RACE</div> <div>Negro</div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>8. DATE OF BIRTH</div> <div>March 6, 1959</div> <div>9. AGE (In years last birthday)</div> <div>2 yrs.</div> <div>IF UNDER 1 YEAR</div> <div>Months Days Hours Min.</div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Institutionalized</div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>--</div> <div>11. BIRTHPLACE (County &amp; State, or foreign country)</div> <div>Washington, D.C.</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div> |  |  |  |  |  |  |  |  |  |  |  |
| <div>13. FATHER'S NAME</div> <div>Wesley Pugh</div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Arlene Beachem</div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>--</div> <div>16. SOCIAL SECURITY NO. (If yes give number of service)</div> <div>--</div> <div>17. INFORMANT</div> <div>SOCIAL SERVICE, CHILDREN'S CENTER, LAUREL, MD.</div> <div>Address</div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Aspiration</div> <div>753.1</div> <div>Conditions, if any, which gave rise to immediate cause (b)</div> <div>Hypoplasia of the brain with hydrocephalus</div> <div>(c)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>Immediate</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>-----</div> <div>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>-----</div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div>21. I certify that (I) (this hospital) attended the deceased from 12/1/60, 19....., that (I) (we) last saw the deceased alive on 3/7/61, 19....., and that death occurred at 8:25 a.m. on 3/7/61, from the causes and on the date stated above.</div> <div>22a. SIGNATURE</div> <div>James E. Boyland</div> <div>M.D.</div> <div>22b. DATE SIGNED</div> <div>March 8, 1961</div> <div>22c. PHYSICIAN'S NAME (Type)</div> <div>James E. Boyland, M.D.</div> <div>22d. ADDRESS</div> <div>Children's Center, Laurel, Md.</div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> <div>23b. DATE THEREOF</div> <div>Mar 9, 1961</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>District Training School</div> <div>23d. LOCATION (City, town or county)</div> <div>Laurel, Maryland</div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>John Switzer Asst. Sup't DTS</div> <div>ADDRESS</div> <div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>MAR 13 '61</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Hume</div>   |  |  |  |  |  |  |  |  |  |  |  |

02862

02862

(M)

James A. Brown

James A. Brown

In 1900

James A. Brown

James A. Brown, 1850 - 1900, 1900, 1900

James A. Brown, 1850 - 1900, 1900, 1900

James A. Brown

James A. Brown

James A. Brown

James A. Brown

James A. Brown

James A. Brown

James A. Brown, 1850 - 1900, 1900, 1900

James A. Brown

James A. Brown, 1850 - 1900, 1900, 1900

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James A. Brown

James A. Brown

James A. Brown, 1850 - 1900, 1900, 1900

James A. Brown

James A. Brown, 1850 - 1900, 1900, 1900

James A. Brown

02643

## MEDICAL CERTIFICATION

VR A15 (4)  
15M 9/60

2163172 XV1

528

600

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2664

02644

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ANNE ARUNDEL</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ft Geo G. Meade</b><br>c. LENGTH OF STAY IN 1b<br><b>1 hr 7 Min</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>U.S. Army Hospital, Ft Geo G. Meade, Md</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>-</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>2000 Mount Royal Terrace</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>ROSS</b><br>Middle<br><b>ROSS</b><br>Last<br><b>ROSS</b>   |                                  | 4. DATE OF DEATH<br>Month<br><b>March</b><br>Day<br><b>20</b><br>Year<br><b>19 61</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>March 20, 1961</b> |
| 9. AGE (In years last birthday)<br><b>1</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months<br><b>1</b><br>Days<br><b>7</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>James Ross</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Delores Elizabeth Harvey</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>N/A</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>N/A</b>  |   |
| 17. INFORMANT<br><b>James Ross, 2000 Mount Royal Terrace, Balto, Md</b>   |                                  | Address<br><b>Balto, Md</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hemoperitoneum; subcapsular hematomas of liver</b><br><b>578X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>petechial pleural surfaces of lungs and pericardium</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b> |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 20, 1961</b> , to <b>Mar. 20, 1961</b> , that (I) (we) lost saw the deceased alive on <b>Mar. 20, 1961</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.  |                                  |  |   |
| 22a. SIGNATURE<br><b>John Z. Fichtner</b>   |                                  | 22b. DATE SIGNED<br><b>March 20, 1961</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN Z. FICHTNER, CAPT, MC</b>   |                                  | 22d. ADDRESS<br><b>U.S. ARMY HOSPITAL, FT GEO G MEADE, MD</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>22 Mar. 61</b>  |                                  | 23b. DATE THEREOF  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>117 Maryland</b>   |                                  | 23d. LOCATION (City, town, or county) (State)  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>William H. Steegs Mt.</b>  |                                  | 25a. REC'D BY REGISTRAR<br><b>Mar 27 '61</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>C. L. F. F. F.</b>   |                                  | 25c. REGISTRAR'S SIGNATURE   |   |

-2050141 XV 3



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2665

CERTIFICATE OF DEATH

Reg. Dist. No. 03870

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Md.</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>12 months</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION <b>District Training School Children's Center, Laurel, Md.</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Rodney</b> Middle <b>Tyrone (Jenkins)</b> Last <b>Scott</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>31</b> Year <b>19 61</b>  |  |   |  |
| 5. SEX <b>male</b>   |  | 6. COLOR OR RACE <b>Negro</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 8. DATE OF BIRTH <b>March 24, 1958</b>  |  |
| 9. AGE (In years lost birthday) <b>3</b> yrs.  |  | 10. IF UNDER 1 YEAR Months <b>3</b> Days <b>31</b> Hours <b>19</b> Min. |  | 11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>   |  |   |  |
| 13. FATHER'S NAME <b>Calvin William Jenkins (putative)</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Wanda Marie Scott</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>   |  |   |  | 16. SOCIAL SECURITY NO. <b>Informant Address Children's Center, Laurel, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b><br>344X DUE TO<br>(b) <b>Hydrocephalus</b><br>DUE TO<br>(c) <b>lying cause lost.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental Retardation</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b> |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>--</b>  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b> p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                             |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>   |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>7/5/60</b> to <b>3/31/61</b> , that I last saw the deceased alive on <b>3/31/61</b> , and that death occurred at <b>11 P. M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Children's Center, Laurel, Md.</b> DATE SIGNED <b>3/31/61</b><br>ACTUAL SIGNATURE <b>George T Economos</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>George T. Economos, M.D.</b>                 |  |   |  |   |  |   |  |
| 22a. BURIAL OR CREMATION <b>CREMATION</b>  |  |   |  | 22b. DATE THEREOF <b>4/5/61</b>   |  |   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>   |  |   |  | 22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Morris A. Carter</b> ADDRESS <b>305 H St. N.W. Washington, D.C.</b>  |  |   |  | 24a. REC'D BY REGISTRAR <b>APR 25 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Charles L. Kiser</b>  |  |   |  |

08838

CERTIFICATE OF DEATH

2863

27

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

John Doe, born [illegible] died [illegible]  
Cause of death [illegible]

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02645

2666

|  |                           |  |   |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>AA</b>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>   |                           | c. LENGTH OF STAY IN 1b<br><b>4 mos.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>518 Morningside Drive</b>   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Emma</b> Middle <b>Sickenberger</b> Last <b>Sickenberger</b>   |                           | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>20</b> Year <b>19 61</b>   |   |
| 5. SEX <b>F</b>  | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 18, 1869</b>  |
| 9. AGE (In years last birthday) <b>92</b>  |                           | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Germany</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Germany</b>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>Johan Conrad Roth</b>  |                           | 14. MOTHER'S MAIDEN NAME<br><b>Dorothea Grebe Klein</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |                           | 16. SOCIAL SECURITY NO. <b>no</b>  |   |
| 17. INFORMANT<br><b>no</b>   |                           | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hypertensive Cardio-Vascular Disease</b><br>DUE TO<br>(c) |                           |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2-20</b> 19 <b>61</b> , to <b>3-20</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>3-19-61</b> 19 <b>61</b> , and that death occurred at <b>6 A.</b> M. from the causes and on the date stated above.  |                           |  |   |
| 22a. SIGNATURE<br><b>C. R. MacDonald M.D.</b>  |                           | 22b. DATE SIGNED<br><b>3-20-61</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>C. R. MacDonald, M.D.</b>   |                           | 22d. ADDRESS<br><b>204 Crain Hwy, SW, Glen Burnie</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                           | 23b. DATE THEREOF<br><b>3/22/61</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillside Cemetery</b>   |                           | 23d. LOCATION (City, town, or county) (State)<br><b>Rutherford, N. J.</b>  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping and Kirkley</b>   |                           | 25a. REC'D BY REGISTRAR<br><b>DATE MAR 21 '61</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Clifford E. House</b>   |                           |  |   |

MEDICAL CERTIFICATION

03030

CERTIFICATE OF DEATH

3303

(M)

(1)

CHAS. J. HARRIS  
HARRIS, CHAS. J.

X

CHAS. J. HARRIS

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2667 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02646**

FOR STATE  
HEALTH DEPT.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>                                   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Queen Ann</u>  |  | c. LENGTH OF STAY IN 1b  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bristol</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Rural</u>  |  |  |  | d. STREET ADDRESS<br><u>1</u>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Ernest</u> First <u>Martha</u> Middle <u>Simms</u> Last   |  |  |  | 4. DATE OF DEATH<br>Month <u>3</u> Day <u>29</u> Year <u>1961</u>  |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>Col.</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                   |  | 8. DATE OF BIRTH<br><u>10-21-1942</u> yrs. <u>18</u>  |  |
| 9. AGE (In years last birthday)<br><u>18</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>   |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Timberman</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Dunkirk, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |  |
| 13. FATHER'S NAME<br><u>Walter Simms</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Elsie Parker</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>No</u>  |  |  |  | 16. SOCIAL SECURITY NO.<br><u>  </u>   |  | 17. INFORMANT<br><u>Elsie Simms - Bristol, Md.</u> Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Crushing Injury to Chest</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Sudden</u><br>(c) <u>  </u>  |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>910-1</u>   |  |  |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.<br><input checked="" type="checkbox"/>  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><u>Tree fell on Subject</u>   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>  </u> o. m. <u>3/29</u> 19 <u>61</u>  |  | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Farm</u>  |  | 20f. (City or town) (County) (State)<br><u>A. A. C. MD</u>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE<br><u>E. Linhardt</u>  |  |  |  | DATE SIGNED<br><u>3-29-61</u>  |  |   |  |
| EXAMINER'S NAME (Type)<br><u>E. Linhardt</u>  |  |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>4-2-61</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Moses</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Drewery, Md.</u>                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>William Reese, Jr. - Annapolis, Md.</u>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>APR 3 '61</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15588

John D. Smith  
(son of)

George D. Smith  
John D. Smith

Age 21 years 10 months 18 days  
Date of Death 10-16-1918  
Place of Death Baltimore, Md.  
Cause of Death Influenza pneumonia  
Manner of Death Natural

|                               |  |                     |  |
|-------------------------------|--|---------------------|--|
| Name of Deceased              |  | John D. Smith       |  |
| Residence                     |  | Baltimore, Md.      |  |
| Occupation                    |  | Student             |  |
| Cause of Death                |  | Influenza pneumonia |  |
| Manner of Death               |  | Natural             |  |
| Signature of Physician        |  | J. H. Smith         |  |
| Signature of Medical Examiner |  | J. H. Smith         |  |
| Signature of Coroner          |  | J. H. Smith         |  |
| Signature of Registrar        |  | J. H. Smith         |  |

J. H. Smith

10-16-1918  
J. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

2668

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02647

|   |  |  |                                   |
|---|--|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>H.A. Co.</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Ind.</u> b. COUNTY <u>A.A. Co.</u>                  |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA PARK</u>  |  | c. LENGTH OF STAY IN 1b <u>25 YRS.</u>   |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 MAPLE AVE</u>   |  | d. STREET ADDRESS <u>110 MAPLE AVE</u>   |                                   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |                                   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH SLAVIN</u>   |  | 4. DATE OF DEATH Month Day Year <u>MARCH 31 1961</u>   |                                   |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>WHITE</u>              | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-23-1884</u> |
| 9. AGE (In years lost birthday) <u>77</u> yrs.  | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Months Days Hours Min.  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                   |
| 13. FATHER'S NAME <u>FRANCIS X. LIVINGSTON</u>  |  | 14. MOTHER'S MAIDEN NAME <u>MARY M. MINNICK</u>  |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>—</u>   |                                   |
| 17. INFORMANT Address <u>MR. FRANK SLAVIN - 108 MAPLE AV.</u>   |  |  |                                   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Degenerative cardiovascular disease</u><br>DUE TO (c) <u>10 yrs.</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>27 Mar</u> 19 <u>61</u> to <u>31 Mar</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>31 Mar</u> 19 <u>61</u> , and that death occurred at <u>5:45</u> P.M. from the causes and on the date stated above.  |  |  |                                   |
| 22a. SIGNATURE <u>Gene D. Trettin</u> M.D.  |  | 22b. DATE SIGNED <u>1 April 1961</u>   |                                   |
| 22c. PHYSICIAN'S NAME (Type) <u>GENE D. TRETTIN</u>   |  | 22d. ADDRESS <u>715 COTTER RD. GLEN BURNIE MD.</u>   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE THEREOF <u>4-4-61</u>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN CEM.</u>   |  | 23d. LOCATION (City, town, or county) (State) <u>GLEN BURNIE, MD.</u>  |                                   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Baranco - Severna Park Md.</u>  |  | 25a. REC'D BY REGISTRAR DATE <u>APR 4 '61</u>  |                                   |
| ADDRESS <u>—</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>  |                                   |

1938

CENTRAL DEATH

2008

(M)



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2669

Items 1c & 2d, film G284 4/12/61 iwk

02648

|  |  |   |  |  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>A.A.</b>  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Crownsville</b>    |  | c. LENGTH OF STAY IN 1b<br><b>8 21 years Mon. 27 dys</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE<br><b>MD</b> |  | b. COUNTY<br><b>A.A.</b>                          |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b> |  | d. STREET ADDRESS<br><b>Solley P.O.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Ronald</b>  |  | First   |  | Middle   |  | Last<br><b>Smith</b>   |  | 4. DATE OF DEATH<br><b>3</b>                      |  | Month<br><b>25</b>   |  | Day<br><b>1961</b>  |  | Year   |  |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>Negro</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9-28-34</b>   |  | 9. AGE (In years last birthday)<br><b>26</b> yrs. |  | IF UNDER 1 YEAR<br>Months Days   |  | IF UNDER 24 HRS.<br>Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>A.A. C. Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |   |  |  |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Charles Smith</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Boxyer</b>  |  |  |  |  |  |   |  |  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>May Smith 2829 Woodbrook Ave</b>  |  | 17. INFORMANT<br><b>May Smith 2829 Woodbrook Ave</b>   |  | Address  |  |   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UK Infection</b><br><b>325.4</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>(b) <b>Mongolian idiocy</b><br>DUE TO<br>(c) |  |   |  |  |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>9 days</b>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |   |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)  |  | (County)  |  | (State)  |  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>3/26/1961</b> to <b>3/25/1961</b> , that (I) (we) last saw the deceased alive on <b>3/25/1961</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.   |  |   |  |  |  |  |  |   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><b>G.B. Wilkins</b>  |  | M.D.  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                     |  | 22b. DATE SIGNED<br><b>3/25/61</b>   |  |   |  |  |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>G.B. Wilkins</b>  |  |   |  | 22d. ADDRESS<br><b>Crownsville Md.</b>   |  |  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>3/28/61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Carmel</b>  |  | 23d. LOCATION (City or town or county)<br><b>Baltimore Md.</b>   |  | (State)   |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>R.R. W...</b>   |  | ADDRESS<br><b>322 Sch...</b>  |  | 25a. REC'D BY REGISTRAR<br><b>MAR 29 '61</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |   |  |  |  |   |  |  |  |

1998

6225

[illegible]

1994

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2670

## CERTIFICATE OF DEATH

Reg. Dist. No.

02649

|   |                                     |   |   |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>life resident</b> X <b>Mayo</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>USNH, Annapolis, Maryland</b>   |                                     | e. STREET ADDRESS<br><b>305 Cadel Avenue</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Maggie</b> Middle <b>Estelle</b> Last <b>STALLINGS</b>  |                                     | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>26</b> Year <b>1961</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Cauc</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar 25 1890</b>                          |
| 9. AGE (In years last birthday)<br><b>71</b> yrs.   |                                     | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |   |
| 13. FATHER'S NAME<br><b>Joseph Tucker (N)</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Emily Owen Howes</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |   |
| 17. INFORMANT<br><b>Mrs Homer Dawson</b>  |                                     | Address<br><b>Mayo Md</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchpneumonia, Bilateral</b><br><b>526X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchiectasis, Emphysema</b><br>DUE TO (c) <b>Chronic Bronchitis</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 Hrs</b><br><b>10 years</b><br><b>20 years</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>   |                                     |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>11 July</b> , 19 <b>60</b> , to <b>26 March</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>26 March</b> , 19 <b>61</b> , and that death occurred at <b>0520A M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>26 March 1961</b>           |                                     |   |   |
| ACTUAL SIGNATURE <b>E. C. Keene</b> M.D.  |                                     |   |   |
| PHYSICIAN'S NAME (Type) <b>E. C. KEENE LT MC USNR</b>   |                                     | <b>USNH, Annapolis, Maryland</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>3-29-61</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mayo Memorial</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Mayo Md</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Taylor Sr</b>  |                                     | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 28 '61</b>   |   |
| ADDRESS<br><b>Annapolis Md</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |   |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2671

## CERTIFICATE OF DEATH

02650

|   |  |  |  |  |   |  |  |
|---|--|--|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Annapolis <span style="float: right;">31 days</span><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>Anne Arundel General Hospital |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <span style="float: right;">Maryland</span><br>b. COUNTY <span style="float: right;">Anne Arundel</span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>X RURAL - Annapolis<br>d. STREET ADDRESS<br>135 Bay Drive - Bay Ridge<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>Richard FREDERICK STONE  |  | <b>4. DATE OF DEATH</b><br>March 13 1961   |  | <b>5. SEX</b><br>Male  |   |  |  |
| <b>6. COLOR OR RACE</b><br>White  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                    |  | <b>8. DATE OF BIRTH</b><br>December 21, 1909   |   |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Engineer  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>U.S. Navy  |  | <b>9. AGE</b> (In years last birthday) 50 yrs.<br>IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____<br>IF UNDER 24 HRS.: _____   |   |  |  |
| <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br>Maryland  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.  |  |  |   |  |  |
| <b>13. FATHER'S NAME</b><br>FRED STONE  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br>CECELIA BRAUN |  |   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give year or dates of service)  |  | <b>16. SOCIAL SECURITY NO.</b>   |  | <b>17. INFORMANT</b><br>Address<br>MARY K. STEELE STONE  |   |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">Carcinoma of the pancreas</span><br>157X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>} DUE TO (c)                    |  |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br>8 mos. |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |   |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. _____ p.m. _____ 19 _____   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) _____ (County) _____ (State) _____  |   |  |  |
| <b>21. I certify</b> that (I) (If deceased) attended the deceased from Feb. 10, 1961 to Mar. 13, 1961, that (I) (If not) saw the deceased alive on Mar. 13, 1961, and that death occurred at _____ M. from the causes and on the date stated above.   |  |  |  |  |   |  |  |
| <b>22a. SIGNATURE</b><br>John L. Hedeman, M.D.  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br><b>22d. ADDRESS</b><br>121 Cathedral St., Annapolis, Md. |  | <b>22b. DATE SIGNED</b><br>3/13/61   |   |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br>John L. Hedeman  |  |  |  |  |   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br>Burial  |  | <b>23b. DATE THEREOF</b><br>Mar 16-1961  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br>Cedar Bluff Cent  |   |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br>John M. Taylor, Annapolis Md   |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE MAR 15 '61  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br>Arthur S. Kraus   |   |  |  |
| <b>23d. LOCATION</b> (City, town or county)<br>Annapolis  |  | (State)<br>Md  |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

05050

1583

11

WILLIAM L. BROWN  
JAMES L. BROWN

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02651

2672

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Anne Arundel</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b><br>c. LENGTH OF STAY IN 1b<br><b>10</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>St. Mary's Rectory</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Anne Arundel</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Annapolis</b><br>d. STREET ADDRESS<br><b>St. Mary's Rectory Gloucester Street</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>JOHN</b><br>Middle<br><b>F.</b><br>Last<br><b>TAUS</b>   |  |  |  | 4. DATE OF DEATH<br>Month<br><b>MARCH</b><br>Day<br><b>28,</b><br>Year<br><b>19 61</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>           |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>Nov. 21, 1909</b>                               |  |
| 9. AGE (In years last birthday)<br><b>51</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months<br><b>51</b> |  | 11. IF UNDER 24 HRS.<br>Days<br><b>51</b>   |  | 12. IF UNDER 24 HRS.<br>Hours<br><b>51</b>                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clergyman</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Church</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>New York, N.Y.</b>     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>John J. Taus</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna M. Kohout</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT<br><b>Rev. John Brennan, Rector, St. Mary's Church</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>434.4</b><br>DUE TO <b>Cancer disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 yrs.</b>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. _____<br>p. m. _____<br>19 _____   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) _____ (County) _____ (State) _____  |  |  |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>Jan 1960</b> , to <b>March 28, 1961</b> , that I last saw the deceased alive on <b>MARCH 28, 1961</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>E. Linhardt</b>   |  |  |  | ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>3/28/61</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Elmer J. Linhardt MD</b>   |  |  |  | <b>Annapolis, Maryland</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>March 30, 61</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Annapolis, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hopping Funeral Home</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br><b>APR 3 '61</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1

2673

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02652

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Anne Arundel</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>   |   | c. LENGTH OF STAY IN 1b <u>55 Yrs.</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>29 Franklin St.</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>M.</u> Last <u>Tull</u>   |   | 4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1961</u>  |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>February 2, 1870</u>  |
| 9. AGE (In years lost birthday) <u>91</u> yrs.  |   | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>James M. Milbourne</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Harriet Dashiell</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO. <u>-</u>   |   |
| 17. INFORMANT <u>Milton L. Tull</u> Address <u># 2</u>  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO <u>Arteriosclerotic-Cerebro-Vascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>422 d</u><br>(c) <u>Fracture of the right hip -</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of the right hip -</u><br>INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u><br><u>4 yrs.</u> |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall down steps 1959 Oct. 1.</u>                         |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>8:00</u> p. m. <u>10:11</u> / <u>1959</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>(Home)</u>   | 20f. (City or town) <u>Annapolis</u> (County) <u>Prin. G.</u> (State) <u>Md</u> |
| 21. I certify that (I) (the hospital) attended the deceased from <u>Oct. 1959</u> to <u>March 1, 1961</u> , that (I) <u>did</u> last saw the deceased alive on <u>3/1</u> / <u>1961</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.   |   |  |   |
| 22a. SIGNATURE <u>Albert L. Anderson</u>  |   | 22b. DATE SIGNED <u>3/3/61</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>Albert L. Anderson</u>  |   | 22d. ADDRESS <u>44 Southgate Ave., Annapolis, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>Mar-4-1961</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Monoken Presbyterian</u>   | 23d. LOCATION (City, town, or county) (State) <u>Princess Anne Md</u>           |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Seaylen Sons</u> ADDRESS <u>Annapolis Md</u>  |   | 25a. REC'D BY REGISTRAR <u>MAR 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>   |   |

08008

CERTIFICATE OF DEATH

2023

*[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields and lines of text.]*

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2678

CERTIFICATE OF DEATH

02658

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>          |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Glen Burnie</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>303 Balto-Annap. Blvd., Ferndale</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>VISKOCIL</b> Last <b>VISKOCIL</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>1</b> Year <b>1961</b>   |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2nd Feb. 1875</b>  |  |
| 9. AGE (In years last birthday)<br><b>86</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.                                      |  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housework (ret.)</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Czechoslovakia</b>                    |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>(unknown) Bel</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Anna (unknown)</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Mr. George Viskocil</b> Address <b>Ferndale, Glen Burnie, Md.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.<br>(b) _____ DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 1954</b> to <b>Feb. 28</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Feb. 25</b> 19 <b>61</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><b>C. R. MacDonald M.D.</b>   |  |   |  | 22b. DATE SIGNED<br><b>3-3-61</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>C. R. MacDonald, M.D.</b>                          |  |
| 22d. ADDRESS<br><b>Glen Burnie, Maryland</b>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>3rd March '61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bohemian National Cem.</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>           |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>A. S. Smith</b>  |  |   |  | ADDRESS<br><b>Glen Burnie, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 6 '61</b>                                      |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>   |  |   |  |

03030

CERTIFICATE OF DEATH

03030

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2674

02653

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>e. COUNTY <i>aa</i><br><b>MARYLAND</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <i>md</i> b. COUNTY <i>aa</i> |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><i>Riva</i>   |                                  |   | c. LENGTH OF STAY IN 1b   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Manor House</i>  |                                  |   | d. STREET ADDRESS<br><i>1211 Scott Drive</i>  |  |   |
| 3. NAME OF DECEASED<br>(Type or print) <i>Heartie Corbett Ward</i>  |                                  |   | 4. DATE OF DEATH<br>Month <i>3</i> - Day <i>22</i> Year <i>1961</i>   |  |   |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Oct 21-1871</i>  | 9. AGE (In years last birthday) <i>89</i> yrs. | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>House wife</i>  |                                  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Crown Pt N.Y.</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A</i>                        |
| 13. FATHER'S NAME<br><i>George Russeel Corbett</i>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Elizabeth Bennett</i>  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                                  |   | 16. SOCIAL SECURITY NO. <i>-</i>  |  |   |
| 17. INFORMANT<br><i>Herman B. Werner</i>  |                                  |   | Address <i>(2)</i>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <i>CEREBRAL ARTERIOSCLEROSIS</i><br>(a), stating the underlying cause last. DUE TO (c) |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>84 HOURS</i><br><i>5 YEARS</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>ARTERIOSCLEROTIC HEART DISEASE</i>  |                                  |   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)                                     |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour e.m. p.m.<br><i>19</i>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)                            | (County) (State)  |
| 21. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>12/27</i> , 1956 to <i>22 MAR</i> , 1961, that (I) <del>(we)</del> last saw the deceased alive on <i>23 MAR</i> , 1961, and that death occurred at <i>1500</i> P.M. from the causes and on the date stated above.                               |                                  |   |   |  |   |
| 22a. SIGNATURE<br><i>Edward S. Beck</i>   |                                  |   | 22b. DATE SIGNED<br><i>3/23/61</i>  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><i>Edward S. Beck</i>   |                                  |   | 22d. ADDRESS<br><i>71 Franklin St., Annapolis, Md.</i>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                                  | 23b. DATE THEREOF<br><i>3-25-1961</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlands Cemetery</i>   |  | 23d. LOCATION (City, town or county) (State)<br><i>Cambridge N.Y.</i> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>John M. Taylor Sons</i>  |                                  |   | 25a. REC'D BY REGISTRAR<br>DATE <i>MAR 27 '61</i>   |  |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Arthur L. Hanna</i>  |                                  |   |   |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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|--|------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>AA</b> <b>MARYLAND</b>   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brooklyn</b>  |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Brooklyn</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>300 Riverside Rd.</b>   |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Anne</b> Middle <b>Marie</b> Last <b>Wehberg</b>   |                              | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>9</b> Year <b>19 61</b>   |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 6, 1914</b> |
| 9. AGE (In years last birthday)<br><b>46</b> yrs.  |                              | 10. IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>10</b> Hours <b>3</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto., Md.</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Balto., Md.</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>Same</b>   |   |
| 13. FATHER'S NAME<br><b>Frederick V. Schofield</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Ida M. Dull</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>Family</b>  |   |
| 17. INFORMANT<br><b>Family</b>   |                              | Address<br><b>Same</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diabetes Mellitus -</b><br>DUE TO <b>260X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.<br>(b) <b>Arteriosclerosis C.V.D.-Cardiac Failure</b><br>DUE TO <b>Chemia - Kimmelsteal-Wilson -</b><br>(c) <b>3 months</b> |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years - 2 years - 3 months</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1960</b> to <b>Mar 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar 9, 1961</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.  |                              |   |   |
| 22a. SIGNATURE<br><b>Paul Schofield</b>  |                              | 22b. DATE SIGNED<br><b>3/10/61</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Paul Schofield</b>  |                              | 22d. ADDRESS<br><b>2301 Annapolis Rd</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>B</b>  |                              | 23b. DATE THEREOF<br><b>3/13/61</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cem.</b>   |                              | 23d. LOCATION (City, town, or county) (State)<br><b>Brooklyn, Md.</b>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>McCully Funeral Homes 130 E. Fort Ave. #30</b>  |                              | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 13 '61</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                              |   |   |

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G284 4/4/61 iwk

2676

## CERTIFICATE OF DEATH

Reg. Dist. No. 02655

|   |                                  |   |   |   |  |  |  |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>AnneArundle</b> <b>MARYLAND</b>   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>3101-4</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jessup</b>   |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>630 Arlington Ave.,</b>                            |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Md. House of Correction Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>Baltimore, Maryland</b>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Samuel L. Wernick</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>26</b> Year <b>19 61</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 12, 1905</b>  |   | 9. AGE (In years last birthday)<br><b>55</b> yrs.                      |  | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>26</b> Hours <b>22</b> Min <b>35</b>        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine shop</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Unknown</b>            |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>America</b>   |
| 13. FATHER'S NAME<br><b>Simon Wernick</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Sira (Maiden name unknown) Wernick</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Denies</b><br>(If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Hospital records</b><br>Address   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420-0</b> DUE TO <b>Congestive Heart Failure</b><br><b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) |                                  |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>January 30, 19 61</b> , to <b>March 26, 19 61</b> , that I last saw the deceased alive on <b>3-26</b> 19 <b>61</b> , and that death occurred at <b>10:30 P.</b> M, from the causes and on the date stated above.   |                                  |   |   |   |  |  |  |
| ACTUAL SIGNATURE <b>Domingo C. Sorongan</b> M.D.  |                                  |   |   | ADDRESS (Street, city or town, state) <b>1213 Light St. Balto 30</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Domingo Sorongan</b>   |                                  |   |   | DATE SIGNED <b>4/1/61</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 22b. DATE THEREOF   |   | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)          |  |
| <b>Burial</b>   |                                  | <b>Or 29-61</b>   |   | <b>Mt Carmel</b>  |  | <b>Balto Md</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Jack Lewis Mc</b>  |                                  |   |   | ADDRESS<br><b>2100 Cutaw Place</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>MAR 29 '61</b>      |  |
|   |                                  |   |   |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Christina S. Mann</b> |  |



## CERTIFICATE OF DEATH

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|  |   |   |  |  |   |   |  |  |
|--|---|---|--|--|---|---|--|--|
| MEDICAL CERTIFICATION  | 1. PLACE OF DEATH<br>a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MD.</u> b. COUNTY <u>H.A.C.</u>                     |  |   |   |  |  |
|  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>MILLERSVILLE</u>   |   | c. LENGTH OF STAY IN 1b<br><u>X</u> <u>MILLERSVILLE</u>  |  |   |   |  |  |
|  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Knottwood Nursing Home</u>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |  |  |
|  | 3. NAME OF DECEASED (Type or print)<br>First <u>MARTHA</u> Middle <u>E</u> Last <u>WILLIS</u>   |   | 4. DATE OF DEATH<br>Month <u>3</u> Day <u>2</u> Year <u>1961</u>   |  |   |   |  |  |
|  | 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>5-13-1879</u>   | 9. AGE (In years last birthday) <u>81</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>                    | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>   |  |
|  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>HOME</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>N. CAROLINA</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
|  | 13. FATHER'S NAME<br><u>WM W. BEZELL</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>MARY FREDERICK</u>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u> |   |  |  |
|  | 16. SOCIAL SECURITY NO.<br><u>  </u>  |   | 17. INFORMANT<br><u>Mrs. DAVID OWEN #2</u>   |  | Address <u>  </u>   |   |  |  |
|  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>491X</u> IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u><br>DUE TO (c) <u>  </u> |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>  |  |
|  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>   |   |  |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>    |  |  |   |   |  |  |
| 20c. TIME OF INJURY<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>61</u>   |   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u> |   | 20f. (City or town) (County) (State) <u>  </u>                        |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JAN 16 1961</u> to <u>MAR 2 1961</u> , that (I) (we) last saw the deceased alive on <u>FEB 27 1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above. |   |   |  |  |   |   |  |  |
| 22a. SIGNATURE<br><u>Gerard Blumel</u>   |   |   |  | 22b. DATE SIGNED<br><u>3/4/61</u>  |   | 22c. PHYSICIAN'S NAME (Type)<br><u>GERARD CHURCH</u>                  |  |  |
| 22d. ADDRESS<br><u>121 CATHERNATE ST ANNAPOLIS MD.</u>   |   |   |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMAINS (Specify)<br><u>BURIAL</u>   |   | 23b. DATE THEREOF<br><u>3-6-61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>HILLCREST</u>                           |   | 23d. LOCATION (City, town, or county) (State)<br><u>ANNAPOLIS MD.</u> |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>John M. Blythe &amp; Sons</u>   |   | 25a. REC'D BY REGISTRAR<br><u>MAR 6 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hines</u>                             |   |   |  |  |

*[Faint handwritten notes at the bottom of the page]*

VR A15 (4)  
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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. [redacted] 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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